



An Adventure
Of a
Lifetime

Medical Certificate

GAN ISRAEL SUMMER CAMP

2014 – 5774
Tel: 760-806-7765
Fax: 760-295-0909

Camper's Name _____ Last Name _____
Insurance Carrier _____ Holder's Name _____
Group Name and Number _____
ID Number _____
Parents Phone: Home: _____
Father's Work: _____ Father's Cell: _____
Mother's Work: _____ Mother's Cell: _____

Medical History

Date

Current Medication

Chicken Pox _____
Measles _____
Mumps _____
Hepatitis _____
Pneumonia _____
Is child treated for the following:
Diabetes ___ Seizures ___
Hay Fever ___ Rheumatic Fever ___
Asthma ___ Frequent Strep ___
Frequent Ear Infection ___

Name Dosage Reason
Other Medical Information:

Restrictions:
Diet _____
Swimming _____
Other _____

Allergies	Yes	No	Comments
Penicillin			
Sulfa			
Aspirin			
Other Drugs			
Foods			
Other:			

Authorization to Consent to Treatment of Minor Temporarily Separate from Parents
I, the parent(s) or Guardian(s) of _____, authorize Gan Israel or
Chabad Jewish Center of Oceanside as our agents to consent to any diagnostic
procedure or medical care which is deemed advisable by any licensed physician
during the days of July 14 – 25, 2014.

Parent's signature _____ Date _____

Please include copy of insurance card.

Copy attached?