MEDICAL PERMISSION REQUEST FORM

ETHEL & IRVING BERKOWITZ GAN ISRAEL DAY CAMP

Director
ESTHER GREENSPAN
esther@chabadpw.org

Camper's Name: _____
Height: _____ Weight: _____ Blood Pressure: _____
Pulse: _____ Vision: *Right:* _____ *Left:* _____
Glasses or other appliances: _____

IMMUNIZATION HISTORY

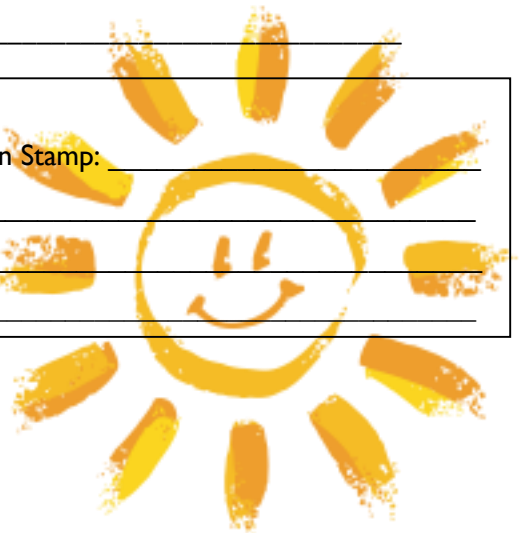
DPaP, DTP or TD: Date _____ Date _____ Date_____ Date _____
Polio: Date _____ Date _____ Date_____ Date _____
MMR: Date _____ Date _____ Date_____ Date _____
HIB: Date _____ Date _____ Date_____ Date _____
Hepatitis B: Date _____ Date _____ Date_____ Date _____
Varicella: Date _____ Date _____
Other _____Date _____ Date _____

Exam	Normal	Abnormal	Description
Eyes			
Ears			
Nose & Throat			
Neck			
Heart			
Lungs			
Abdomen			
Genitals			
Skin			
Extremities			
Spine			
Neurological			
Other			

Operations/previous illness: _____
Medications: _____
Special conditions: _____

On the basis of my medical examination and the child's past history, it is my opinion, the above child
☐May ☐ May not participate in all activities.
Limitations: _____

Physician's Signature: _____ Physician Stamp: _____
Physician's Name: _____
Address: _____
Phone: _____ Date of Exam: _____



Please mail or email this form to:

A Program of Chabad of Port Washington
80 Shore Road • Port Washington, NY 11050
P 516 767 TORAH • chabadpw.org

MEDICAL PERMISSION REQUEST FORM

ETHEL & IRVING
BERKOWITZ
GAN ISRAEL
DAY CAMP

Director
ESTHER GREENSPAN
esther@chabadpw.org

In accordance with the Nassau County Department of Health any camper needing medication during camp hours must do the following:

1. Present a written consent form signed by a parent or legal guardian
2. Bring the medication in the original prescription bottle, properly labeled by a registered pharmacist as prescribed by law
3. Submit this completed medication permission from the prescribing physician

TO BE COMPLETED BY PARENT:

Name of camper: _____ Date of Birth _____

Name of camp: Berkowitz Gan Israel Day Camp

I, _____, give permission for my child to receive the medication(s) specified below as directed.

Parent /Guardian Signature _____ Date_____

TO BE COMPLETED BY PHYSICIAN:

Medication	Dosage Per Pill (mg)	Number of Pills per Dosage	Total Dosage	Times – am / pm

Are there any restrictions? ___Yes ___No

If yes, what and how long?

_____

The following side effects are common:

_____

The following side effects should be reported to me:

_____

_____

Physician's Signature _____

Physician's Name Printed _____

Physician's Phone _____

Date _____

A Program of Chabad of Port Washington
80 Shore Road • Port Washington, NY 11050
P 516 767 TORAH • chabadpw.org