

**COMPREHENSIVE INFORMATION SHEET**

Camper's Name \_\_\_\_\_ Gender \_\_\_\_\_ Date of Birth \_\_\_\_\_ Age \_\_\_\_\_  
 (last) (first) (middle)  M  F

Parent's name(s) \_\_\_\_\_ Home Phone (\_\_\_\_) \_\_\_\_\_

Home address \_\_\_\_\_

Mother/work # (\_\_\_\_) \_\_\_\_\_ Cell (\_\_\_\_) \_\_\_\_\_ Carrier \_\_\_\_\_  Send me SMS text alerts at this number

Father/work # (\_\_\_\_) \_\_\_\_\_ Cell (\_\_\_\_) \_\_\_\_\_ Carrier \_\_\_\_\_  Send me SMS text alerts at this number

Family Doctor/address \_\_\_\_\_ Phone(\_\_\_\_) \_\_\_\_\_

**TWO EMERGENCY CONTACTS OTHER THAN PARENTS (give name, relationship and phone numbers)**

1. \_\_\_\_\_

2. \_\_\_\_\_

Medical Insurance \_\_\_\_\_ Policy # \_\_\_\_\_

Previous Camp Experience \_\_\_\_\_

**MEDICAL QUESTIONNAIRE**

(A doctor's report is not required. Parents may complete.)

Date of last exam \_\_\_\_\_ Recent Surgery? \_\_\_\_\_ Recent serious illness? \_\_\_\_\_

Any allergies? \_\_\_\_\_ Medication on a regular basis? \_\_\_\_\_

**IMMUNIZATION - PLEASE GIVE DATES!**

Diphtheria \_\_\_\_\_ Tetanus \_\_\_\_\_

Polio \_\_\_\_\_ TB \_\_\_\_\_

Diabetes \_\_\_\_\_ Mumps \_\_\_\_\_

**DOES YOUR CHILD HAVE A HISTORY OF:**

Heart Disease \_\_\_\_\_ Epilepsy \_\_\_\_\_

ADD or ADHD \_\_\_\_\_ Asthma \_\_\_\_\_

Ear/Sinus infection \_\_\_\_\_ Measles \_\_\_\_\_

Does your child have any mental or social disabilities or any physical problems of which we need to be aware?  
 \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

**I HAVE READ THE PARENT'S HANDBOOK AND AGREE TO ABIDE BY ALL OF THE POLICIES OF CAMP GAN ISRAEL**

**CAMP GAN ISRAEL HAS MY PERMISSION TO RENDER ANY NECESSARY FIRST-AID OR CARE TO MY CHILD WHILE HE/SHE IS ATTENDING CAMP.**

**CAMP GAN ISRAEL HAS MY PERMISSION TO OBTAIN MEDICAL CARE FOR MY CHILD FROM CAMP SELECTED PHYSICIAN OR MEDICAL PROVIDER IF NECESSARY.**

**CAMP GAN ISRAEL HAS MY PERMISSION TO USE ANY PHOTOGRAPHS/VIDEOS OF MY CHILD TAKEN DURING CAMP FOR PUBLICATION.**

**Signed:** \_\_\_\_\_ **Date** \_\_\_\_\_  
 (parent or guardian)