B"H

2024 HEALTH RECORD

CAMP GAN ISRAEL OF ROSLYN

75 Powerhouse Road, Roslyn Heights, NY 11577. Phone: (516) 484-3500. Email: info@ganisraelroslyn.com

THIS FORM IS TO BE COMPLETED BY PHYSICIAN

(Physician may also use his/her own form)

Camper's Name: _____Date of Birth: _____

Height: _____ Weight: _____ Blood Pressure: _____ Pulse: _____

Vision: Right: _____ Left: _____ Glasses or other appliances: _____

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

Operations/previous illness: _____

Medications: _____

Special conditions: _____

IMMUNIZATION HISTORY (may alternatively attach separate immunization form)

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 _____

In 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: _____

Date of exam must be within twelve months of the child's last day attending camp