CAMP GAN ISRAEL

487 Parksville Road. Parksville, NY 12768
Tel: (845) 292 9307

NO FAXES

Confidential Medical and Consent Form

ORIGINAL FORMS ONLY

Please return this form to:
Camp Gan Israel, 770 Eastern Pkwy, Suite 209
Brooklyn, NY 11213

Camper's name: _____

Home address: _____

City: _____ State: _____

Country: _____ Zip/postal code: _____

Date of Birth: _____ Present age: _____

The above camper will be attending the following trips: ❒First ❒Second

Home phone #: (_____) _____ Summer Phone #: (_____) _____

Father's business #: (_____) _____ Name of bungalow colony: _____

Mother's business # (_____) _____ In emergency, call: Name: _____

Cell phone # (_____) _____ Phone #: _____

If your child has a chronic or acute medical condition, it is imperative that the camp be notified. To speak to the camp medical staff regarding your child's confidential medical information, please call them by June 1st at the number at the top of this form. All information will be held confidential.

MEDICAL & PRESCRIPTION DRUG INSURANCE INFORMATION

Please make a copy of your medical insurance card and paste it in the left box below. If you have separate prescription drug coverage, make a copy of that card and pace it in the right box below. ***If no cards are attached, you will be billed for your child's medical insurance and prescription drugs at regular rates.***

Paste a copy of the medical insurance card here.
Please remember to complete the insurance information section on page 2

❒ I do not have medical insurance

Paste a copy of the back of your medical insurance card here.

Paste a copy of the front of your prescription drug card here.

❒ My medical & drug coverage is the same

❒ I do not have drug coverage

Turn over ➔

TO BE COMPLETED BY PARENTS

Insurance information:

Company name_____ Policy in name of: _____

Relationship: _____ Group name and number: _____ ID number: _____

Other/secondary insurance carrier and identification information, if different from above: _____

_____

To assist us in the care of your child, please detail any special circumstances or conditions that our medical or counseling staff should be aware of (e.g. frequent colds, headaches, stomachaches, diarrhea/constipation, vomiting, bed-wetting, sensitivity to insect bites, homesickness, nightmares, anxiety reactions etc),and what you would recommend as treatment:

_____

_____

Important note: The camp office **must** be notified if your child is exposed to any communicable disease during the three weeks prior to camp attendance.

DEPARTMENT F HEALTH REGULATIONS REQUIRE THE FOLLOWING AUTHORIZATIONS IF YOUR CHILD ATTENDS A SLEEP-AWAY CAMP:

PARENTS' AUTHORIZATION TO TREAT & MENINGITIS VACCINATION RESPONSE

SIGNATURE REQUIRED TO ATTEND CAMP

1. This health history is correct as far as I know, and the person herein described has permission to engage in all prescribed camp activities except as noted to me and the examining physician.

2. I hereby give permission to the physician selected by the camp director to order x-rays, routine tests and treatment for the health of my child. In the event that I cannot be reached in an emergency, I hereby give permission to the physician selected by the camp director to hospitalize, secure proper treatment for, order injections and/or anesthesia and/or surgery for my child as named above.

3. I have read the camp letter describing Meningitis, its transmission, the benefits, risks and effectiveness of immunization, availability and cost. (Please check one box and sign below)

❒ My child has had the meningococcal meningitis immunization (Menomune) within the past 10 years. Date received: _____

❒ I have read, or have had explained to me, the information regarding meningococcal meningitis disease. I understand the risks of not receiving the vaccine. I have decided that my child will **not** obtain immunization against meningococcal meningitis disease.

_____	_____	_____
Parent's signature	Witness' signature	Date

AUTHORIZATION TO CONSENT TO TREATMENT OF MINOR TEMPORARILY SEPARATED FROM HIS/HER PARENTS

I/We, the undersigned parents of _____, a minor, do hereby authorize Camp Gan Israel, and/or Rabbi Joseph Y Futerfas, Director, as our agent(s) to consent to any diagnostic procedure or medical care for said child which is deemed advisable by, and is rendered under the general or special supervision of any licensed physician or surgeon at Catskill Regional Medical Center (formally Community General Hospital of Sullivan County) or at any other accredited hospital, when such diagnosis or treatment is rendered at said hospital.

It is understood that this authorization is given in advance of any specific need for treatment, but is given to provide authority on the part of our aforesaid agent(s) to give specific consent to any and all such diagnosis, treatment or hospital care which the physician in the exercise of his best judgment may deem advisable.

This authorization shall remain effective until August 13, 2018, unless sooner revoked in writing and delivered to said agent(s).

Parent(s) signature: _____ Date: _____ Phone #: _____

Witness signature:_____ Date: _____

Permanent address: _____

Temporary address/name of bungalow colony:_____

TO BE COMPLETED BY EXAMINING PHYSICIAN

Camper's name: _____
Home address: _____ **City:** _____ **State:** _____
Zip/postal code: _____ **Country:** _____
Weight: _____ **Height:** _____

Immunization History:

Please record month and year of basic immunizations and most recent booster. Please do not call our office for this information. We do not have it on his file from previous years.

Immunization	Date basic series completed	Most recent booster.
DPT or DT		
Tetanus		
Oral Polio		
MMR		
HIB		
Hepatitis A		
Hepatitis B		
Varicella		

Allergies:	Yes	No	Comments
Penicillin			
Sulfa			
Cephalosposrins			
Other medication			
Food allergies List foods your child is allergic to.			
Bees/insect bites			

Has your child ever had an anaphylactic reaction?
❒ Yes ❒ No,
IF YES, YOU MUST SEND AN EPI-PEN ALONG WITH YOUR CHILD. (CHECK THAT IT HAS NOT EXPIRED OR YOU WILL BILLED FOR ONE ONCE IN CAMP.)

Medical History: Indicate date of illness

Chicken Pox _____
Measles _____
German measles _____
Mumps _____
Hepatitis _____
Pneumonia _____

❒Positive PPD Date: _____
CXRay:_____ Date: _____
Treatment protocol_____

Indicate if being treated for the following:
❒ Diabetes ❒ seizures ❒ seasonal allergies
❒ Rheumatic fever
Frequent ❒ Ear infections ❒ Strep throat
❒ Asthma (If your child is being treated for asthma, please send along the tubing for the nebulizer as well as all inhalers being used **AND MAKE SURE THAT THE NURSE IS NOTIFIED BEFORE CAMP BEGINS.**

Individualized Orders
Standard over-the counter/PRN Medications
(Available in infirmary/First Aid Kit) To be administered at the discretion of the RN unless

Drug or generic equivalent	Route	Dosage	Schedule	Contra-indicated	Comments
Tylenol	PO	Per label instructions by age/weight	Q 3-4 hr prn for discomfort or elevated temp		
Ibuprofen	PO	Per label instructions by age/weight	Q 6hr prn for discomfort or elevated temp		
Robitussin	PO	Per label instructions by age/weight	Q 4-6 prn for cough		
PeptoBismol	PO	Per label instructions by age/weight	Q 30 min to 1 hr prn for diarrhea (not>8 doses/24 hr)		
Mylanta	PO	Per label instructions by age/weight	TID-QID prn for gastric upset		
Dramamine	PO	Per label instructions by age/weight	½ hr b4 embarkation, then q 6-8 hr prn for motion sickness		
Dimetapp	PO	Per label instructions by age/weight	Q 6-8 hr for nasal congestion/drainage		
Benadryl	PO	Per label instructions by age/weight	Q 6hr prn for allergic reaction		
Sudafed	PO	Per label instructions by age/weight	Q 6-8 hr for nasal congestion/drainage		
Tums	PO	Per label instructions by age/weight	Q 30 min prn for gastric upset/heartburn		
NaphconA		Per label instructions by age/weight	1-2 gtts affected eye q 4-6 hr itching/burning		
Milk of Magnesia	PO	Per label instructions by age/weight	BID-TID prn for gastric upset/constipation		
Ear Drops		Per label instructions by age/weight	Apply to affected area as indicated		
Cortisone Ointment		Per label instructions by age/weight	Apply to affected area as indicated		
Antifungal Ointment Spray		Per label instructions by age/weight	Apply to affected area as indicated		

❒ Check here if doctor is enclosing a separate signed form regarding the above information.

Dear Doctor, (signature required)

List dates & description of operations, serious injuries or fractures: _____

_____

Chronic or recurrent illness and suggested treatment: _____

_____

SPECIAL RESTRICTIONS:

Diet: _____

Swimming: _____

Strenuous activity: _____

Other: _____

_____

_____

To the best of my knowledge the information stated above is true and accurate and it is my opinion that the camper named above in physically able to engage in all camp activities, except as noted above.

Physician's signature: _____ Date: _____

Physician's name: _____ Emergency phone #: _____

Address: _____

Parents, please note:

- If your child comes to camp with "over-the-counter" medications, try to make sure that they have enough for the entire trip or summer. Some of the more usual over-the-counter medications are not readily available at upstate pharmacies. These medications must be kept in the infirmary.
- If your child is coming to camp with year-round prescription medication, we must have a note from your doctor detailing the medication prescribed, the dosage, the time and frequency that it should be taken and the reasons for taking the medication. No **unlabeled medication** will be dispensed. Verbal information about medication is insufficient. All medications must be kept in the infirmary.
- At the suggestion of our doctors, allergy medications/shots should be started about a month prior to camp to facilitate relief during the summer. We will be glad to continue the treatments.
- To avoid any possible embarrassment and discomfort of your child, please be sure to check him thoroughly for the presence of lice prior to sending him to camp. (it is in your child's best interest to address this problem at home, even at the expense of missing the first few days of camp.)

Your medical form will be returned if:

- **Consent form is not signed in both places. (page 2)**
- **Immunization dates are not listed. (page 3)**
- **Individualized orders section is not complete. (page 3)**
- **Doctor's name and phone number are not listed. (see above)**
- **It is not signed by your doctor. (see above)**
- **Any section, or part thereof, is omitted that can affect the safe treatment of your child.**

Return this form no later than June 1st to:
Camp Gan Isreal, 770 Eastern Pkwy, Suite 209, Brooklyn 11213

INCOME ELIGIBILITY FORM
FOR THE
SUMMER FOOD SERVICE PROGRAM
(For Use by Camps and Closed Enrolled Sites)

Please complete the following form using the instructions below. Sign the form and return it to: Camp Gan Israel _____.

If you need help, call 1-845-292-9307

Follow these instructions, if your household gets SNAP (Food Stamps) TANF or FDPIR:

Part 1: List participant's name and a SNAP (Food Stamp), TANF or FDPIR case number.
Part 2: Skip this part.
Part 3: Skip this part.
Part 4: Sign the form. A Social Security Number is NOT required.
Part 5: Answer this question if you choose to.

If your household includes a FOSTER CHILD, use one application for the whole household and follow these instructions:

Part 1: Enter the child's name.
Part 2: Please contact us at **[845-292-9307]**
Part 3: Complete this part if you are applying for other children in the household and you did not enter a SNAP (Food Stamp), TANF or FDPIR case number in Part 1.
Part 4: Sign the form. If Part 3 was completed, provide the last four digits of the signing adult's Social Security Number.
Part 5: Answer this question if you choose to.

ALL OTHER HOUSEHOLDS, including WIC households, follow these instructions:

Part 1: List each participant's name.
Part 2: Skip this part.
Part 3: Follow these instructions to report total household income from last month.

Column A–Name: List the first and last name of **each** person living in your household, related or not (such as grandparents, other relatives, or friends who live with you). You must include yourself and all children living with you. Attach another sheet of paper if you need to.

Column B–Gross income last month and how often it was received. Next to each person's name, list each type of income received last month, and how often it was received.

In Box 1, list the **gross income** each person earned from work. This is not the same as take-home pay. **Gross income is the amount earned before taxes and other deductions.** The amount should be listed on your pay stub, or your boss can tell you. Next to the amount, write how often the person got it (weekly, every other week, twice a month, or monthly).

In box 2, list the amount each person got last month from welfare, child support, alimony.

In box 3, list Social Security, pensions, and retirement.

In box 4, list ALL OTHER INCOME SOURCES including Worker's Compensation, unemployment, strike benefits, Supplemental Security Income (SSI), Veteran's benefits (VA benefits), disability benefits, regular contributions from people who do not live in your household. Report net income for self-owned business, farm, or rental income. Next to the amount, write how often the person got it. If you are in the Military Housing Privatization Initiative do not include this housing allowance.

Column C–Check if no income: If the person does not have any income, check the box.

Part 4: An adult household member must sign the form and include the last four digits of his or her Social Security Number, or mark the box if he or she doesn't have one.
Part 5: Answer this question if you choose to.

Privacy Act Statement: The Richard B. Russell National School Lunch Act requires the information on this application. You do not have to give the information, but if you do not, we cannot approve your child for free or reduced price meals. You must include the social security number of the adult household member who signs the application. The social security number is not required when you apply on behalf of a foster child or you list a SNAP, Temporary Assistance for Needy Families (TANF) Program or Food Distribution Program on Indian Reservations (FDPIR) case number for your child or other (FDPIR) identifier or when you indicate that the adult household member signing the application does not have a social security number. We will use your information to determine if your child is eligible for free or reduced price meals, and for administration and enforcement of the Program.

Non-discrimination Statement: In accordance with Federal law and U.S. Department of Agriculture policy, this institution is prohibited from discriminating on the basis of race, color, national origin, sex, age, or disability. To file a complaint of discrimination, write to *USDA, Director, Office of Civil Rights, 1400 Independence Avenue, SW, Washington DC 20250-9410* or call (800) 795-3272 or (202) 720-6382 (TTY). USDA is an equal opportunity provider and employer.

Part 1. Children enrolled in Camp or Closed Enrolled Sites.

Names (First, Middle Initial, Last)	SNAP (Food Stamp), TANF or FDPIR case # (if any). **Skip to Part 4 if you listed a case #.**

Part 2. Foster Child

Foster children eligible for free and reduced-price meals regardless of household income. If a foster child lives with you, please contact **[name of Sponsor]** at **[845-292-9307]**. Complete Part 3 if you are applying for other children in your household and you did not enter a SNAP (Food Stamp), TANF or FDPIR case number in Part 1.

Part 3. Total Household Gross Income—You must tell us how much and how often

A. Name (List **everyone** in household, including children)	**B. Gross income and how often it was received** *Example: $100/monthly $100/twice a month $100/every other week $100/weekly*				**C. Check if NO income**
	1. Earnings from work before deductions	2. Welfare, child support, alimony	3. Social Security, pensions, retirement,	4. All Other Income	
1.	$_____/_____	$_____/_____	$_____/_____	$_____/_____	❑
2.	$_____/_____	$_____/_____	$_____/_____	$_____/_____	❑
3.	$_____/_____	$_____/_____	$_____/_____	$_____/_____	❑
4.	$_____/_____	$_____/_____	$_____/_____	$_____/_____	❑
5.	$_____/_____	$_____/_____	$_____/_____	$_____/_____	❑
6.	$_____/_____	$_____/_____	$_____/_____	$_____/_____	❑
7.	$_____/_____	$_____/_____	$_____/_____	$_____/_____	❑
8.	$_____/_____	$_____/_____	$_____/_____	$_____/_____	❑
9.	$_____/_____	$_____/_____	$_____/_____	$_____/_____	❑
10.	$_____/_____	$_____/_____	$_____/_____	$_____/_____	❑
11.	$_____/_____	$_____/_____	$_____/_____	$_____/_____	❑
12.	$_____/_____	$_____/_____	$_____/_____	$_____/_____	❑

Part 4. Signature and Social Security Number (Adult must sign)

An adult household member must sign this form. If Part 3 is completed, the adult signing the form must also list the last four digits of his or her Social Security Number or mark the "I do not have a Social Security Number" box. (See Privacy Act Statement on the back of this page.)

I certify that all information on this form is true and that all income is reported. I understand that this information is being given for the receipt of Federal funds. I understand that SFSP officials may verify the information. I understand that if I purposely give false information, the participant receiving meals may lose the meal benefits, and I may be prosecuted.

Sign here: X_____Print name:_____Date: _____
Address:_____Phone Number:_____
Last four digits of Social Security Number: __ __ __ __ ❑ I do not have a Social Security Number

Part 5. Participant's ethnic and racial identities (optional)

Mark one ethnic identity:	Mark one or more racial identities:	
❑ Hispanic or Latino ❑ Not Hispanic or Latino	❑ Asian ❑ White ❑ Black or African American	❑ American Indian or Alaska Native ❑ Native Hawaiian or Other Pacific Islander

Don't fill out this part. This is for official use only.

Annual Income Conversion: Weekly x 52, Every 2 Weeks x 26, Twice A Month x 24, Monthly x 12
Total Income: _____ Per: ❑ Week, ❑ Every 2 Weeks, ❑ Twice A Month, ❑ Month, ❑ Year
Household size: _____
Categorical Eligibility: ___ Date Withdrawn: _____ Eligibility: Free___ Reduced___ Denied___
Reason: _____
Determining Official's Signature: _____ Date: _____
Confirming Official's Signature: _____ Date: _____
Follow-up Official's Signature: _____ Date: _____