



Health Form - 2009

Machane Yisrael

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Camper Information

Full Name: _____ Date: _____
Last First M.I.

DOB _____ Age as of June _____

Health History

ALLERGIES

Bee stings Penicillin Other _____

Check all relevant conditions:

- Frequent ear infections Bleeding/clotting disorders* Measles
- Heart defect/disease* Hypertension Asthma*
- Convulsions/epilepsy* Mononucleosis Mumps
- Diabetes* Chicken pox Eating disorder*

Describe any medical conditions (including dates if necessary) _____

Dietary restrictions: _____

Current Medication	Prescribing physicians name and phone number		
Name	Reason	Dosage	Time of day given

Any dizziness, lightheadedness, fainting associated with exercise in the past year.

- ***If yes, include a detailed letter from your doctor describing the situation and treatment. This letter will be kept confidential and under the discretion of the medical personnel.***

Immunization History

IMMUNIZATION	YES	NO	DATE	IMMUNIZATION	YES	NO	DATE
Diphtheria				Tetanus			
German Measles				Hepatitis A			
Measles				Hepatitis B			
Mumps				Whooping Cough			
Polio (Salk)				Other:			
Polio (Oral Sabin)				Other:			

These immunizations are not required by Israel. Immunization should be based on consultation with physician.

Physician's Signature _____ Date _____