רח' האומן 18 ירושלים 93420
טל: 02 648 3758
פקס: 02 648 1370
www.kobymandell.org
18 HaUman St. Jerusalem 93420
info@kobymandell.org
מס' עמותה: 58-039-505-1

ב"ה

קובי מנדל
The Koby Mandell Foundation

CAMP KOBY SUMMER PROGRAM
MEDICAL FORM

Part 1: To be completed by parent or guardian of applicant

Name: __________________ __________________ Sex ☐ M ☐ F Birth date: ____/_____/____
Last First

Address: ________________________ City: _______________ State: __________ Zip: __________

Phone Numbers: _______________________ ________________________ __________________
Home Father's business Mother's business

A. Emergency Contact (other than parents):

Name: __________________ __________________ Relationship: ________________
Last First

Address: _____________________________ Phone: __________________________

B. Health Coverage

Name of Family Doctor: ____________________ Phone: _______________________

Name of dentist/orthodontist: ______________________ Phone: _______________________

Health Insurance Company: _______________________ Policy Number: __________________

Address: _____________________________________ Phone: _______________________________

Please enclose a copy of your medical insurance form

C. Authorization:

I certify that all information in this medical form is true and accurate and there has been no willul omission of data. My child has permission to engage in all prescribed Camp Koby programs in Israel activities except as noted.

Emergency Authorization: I hereby give permission to the medical personnel selected by the Koby Mandell Foundation's director to order X-rays, routine tests, and treatment for my child, and, in the event that I cannot be reached in an emergency, I hereby give permission to the physician selected by the Koby Mandell Foundation Director to hospitalize, secure proper treatment for, and to order injection and/or anesthesia and/or surgery for my child as named above. This form may be photocopied for use off of campus.

Signature of parent or guardian: ______________________________ Date: _____________________________

Participant: I also understand and agree to abide with the medical restrictions placed on my activities while part of the program in Israel.

Signature of participant: ______________________________ Date: ____________________

D. Health History

1. Check all relevant conditions:

- Frequent ear infections
- Heart defect/disease*
- Convulsions/epilepsy*
- Diabetes*
- Bleeding/clotting disorders*
- Hypertension
- Hay fever/Rose fever

- Mononucleosis
- Chicken pox
- Measles
- German measles
- Mumps
- Eating disorder*
- Asthma*

Allergies

- Bee stings
- Drugs ___________________
- Other ___________________
- Foods ___________________

____
- Other ___________________

2. Describe any operations or serious injuries (including dates) ____________________________

____
____
____

3. Disability or chronic or returning illness ____

____

4. Has the applicant been under psychiatric or psychological care within the last two years? Yes* No

* **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.**

Part II: To be completed in detail by a physician who has examined the applicant **within the last three months.**

A. Measurements:

Height ________________ Weight __________________

B. Immunization History:

Has the participant been protected against (check and note year of most recent immunization):

Immunization	**Yes**	**No**	**Date**		**Immunization**	**Yes**	**No**	**Date**
Diptheria					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. Immunizations should be based on consultation with physician

C. Health Examination: Applicant's Name ____________________

The applicant is under the care of a physician and/or therapist for the following conditions:

Current treatment (include current medications):

Explanation of any reported loss of consciousness, convulsions or concussion:

D. Recommendations and Restrictions while in Israel:

Treatments to be continued in Israel: ____________________

Medically prescribed meal plan or dietary restrictions: ____________________

Allergies (food, drugs, plants, insects, etc.): ____________________

Restrictions to full participation: ____________________

I have examined the above applicant within **THE LAST THREE MONTHS**. In my opinion, the above applicant's condition:

☐ **Does** ☐ **Does not** preclude his/her participation in an active camping program.

Licensed Physician's Name

Date of Examination

Licensed Physician's Signature

Address

Phone Number

Fax Number

Date of Form Completion

By (Initial if completed by nurse or physician's assistant)