



Camp B'nai Brith

1 Carre Cummings Square, Suite 232
Montreal, Quebec, H3W 1M6
Tel. (514) 735 3669
Fax (514) 735 8197
www.cbbmtl.org

2010 CAMP MEDICAL REPORT
MUST BE COMPLETED IN FULL
IN ORDER TO BE ACCEPTED

Family Name _____ First Name _____ Sex _____

Address _____ Telephone No. _____

Birthday _____ Medicare No. _____ Expiry Date _____
day / month / year

Persons to notify in case of emergency

Name (Parents / Guardian) _____

Home No. _____ Work No. _____ Cell No. _____

Name _____ Relationship to camper _____

Home No. _____ Work No. _____ Cell No. _____

Name _____ Relationship to camper _____

Home No. _____ Work No. _____ Cell No. _____

If unable to reach the emergency contact individual(s) above, Camp B'nai Brith Director(s) are hereby authorized to act in accordance with their judgment in the prevailing circumstances.
Signature of Parent or Guardian _____ Date _____

Questions to be answered by the parents / guardian

Are there any problems, medical or otherwise that the doctor / nurse should know about? (i.e. bedwetting, sleepwalking, phobias, etc.)

Please list and explain any restrictions, in terms of activities, that your child may have for camp (i.e. swimming, strenuous activity).

Does your child take any medications and will he / she be taking them at camp?

Does your child wear glasses / contact lenses / braces / retainer? (please circle all that apply)
Contact information for the orthodontist or dentist: _____

Is your child being followed by any other physicians and / or mental health workers? Yes No

If YES, please give their names and contact numbers: _____

Does your child have any dietary restrictions?

This Section Must Be Completed And Signed By A Physician

Please indicate any medical or surgical history, with approximate dates:

VACCINATIONS:

Please Indicate date of Last Tetanus Booster: _____

Are all other vaccinations up to date? Yes No

If NO, please indicate which vaccines are missing: _____

Does this person have any allergies to medication? Yes No

If YES, please indicate which medication AND the previous reaction. _____

Does this person have any allergies to food / animals / insects? Yes No

If YES, please indicate the allergy and the degree of severity. _____

Does this person take any medication on a regular, or on an at need basis? Yes No

WILL MEDICATION BE TAKEN DURING CAMP SEASON? Yes No

If YES, please indicate the medication with the indication of dosage. _____

If medication is taken during the school year, but NOT during the summer, an explanation is required: _____

MEDICAL EXAMINATION: Date: _____ (Within Three (3) Months of Camp)

(Please indicate any abnormalities on exam) Height: _____ Weight: _____ Blood Pressure: _____

I have examined _____ and have reviewed his/her history. It is my opinion that he/she is physically able to attend camp and is free from communicable or infectious diseases and is able to engage in all activities except as noted on this health form.

Physician's Name: _____ Signature: _____ Date _____

Address: _____ Phone No.: _____

