CAMP KIBBUTZ
MEDICAL IMMUNIZATION FORM

(one per camper/C.I.T. – to be completed by a Physician)

CAMPER INFORMATION	
Camper Name:	DOB:

THIS FORM MUST BE SUBMITTED WITH THE CAMP REGISTRATION FORM FOR EACH CAMPER PRIOR TO THE CHILD'S FIRST DAY OF CAMP. NO CHILD WILL BE ACCEPTED WITHOUT THIS HEALTH FORM SIGNED BY A PHYSICIAN.

CAMPER'S HEALTH HISTORY
Please describe the above-listed camper's medical history, including any medical conditions or medications that the camper may be taking that the Camp Kibbutz should know about (attach additional sheets if necessary):
Please list any allergies to medications, foods, plants, etc. and expected reaction and treatment (attach additional sheets if necessary):

IMMUNIZATION RECORD

Per District of Columbia requirements, an immunization record, including dates against diphtheria, hemophilus influenza b, hepatitis b, measles, mumps, poliomyelitis, rubella, tetanus and varicella is to be kept on file for each camper.

Please attach complete immunization record for the above child to this form.

(If your child has not received all of the required immunizations, he or she will not be able to attend Camp Kibbutz.)

PHYSICIAN'S AUTHORIZATION

The above-listed camper was examined on ___ / ___ / ___ and found to be in satisfactory health and free from any communicable disease(s). There is no reason that this child should not participate in the routine activities associated with camp and swimming activities.

Physician's Signature:	Date:
Physician's Name (please print):	Phone:
Mailing Address:	City, St. Zip:

CAMP KIBBUTZ

PRESCRIPTION MEDICATION AUTHORIZATION

(one per camper/C.I.T. – Requires Physician's signature)

CAMPER INFORMATION	
Camper Name:	DOB:

TO BE FILLED OUT BY PHYSICIAN	
I certify that, in my opinion, it is medically necessary that the medication described below be administered to the above camper during camp hours (including Camp Kibbutz: Day overnights and Camp Kibbutz: Away) and that this medication may be administered by camp staff.	
Prescription:	Medication: Dosage and Time: Duration: ❑ while attending Camp Kibbutz ❑ For the following time period:
This medication needs to be brought on field trips by a staff member: ❑ Yes ❑ No	
This medication needs to be brought to all outdoor activities by a staff member: ❑ Yes ❑ No	
Physician Signature:	Date:

TO BE FILLED OUT BY THE PARENT/GUARDIAN	
I, ____________________, the parent or guardian of the above listed camper, request that the camp staff administer the medication prescribed above to my child during camp hours (including camp overnights). I understand that the person who will administer the medication may not be a medical professional. I also agree to furnish said medication in the container supplied by the drug store with the label intact.	
Parent/Guardian Signature:	Date:

Staff may not accept medication until this form is filled out in its entirety. All medications must be in original packaging. Prescription medication must have pharmacy label. All medications must be given to a camp counselor and not sent with children.