



CAMP ORAYSA

A DIVISION OF MESIVTA CHAIM SHLOMO - BAIS MEDRASH HEICHAL DOVID

Administrative Office:
257 Beach 17th St. • Far Rockaway, NY 11691
718.868.2300 ext. 490

Camp Address:
228 Todd Road • Woodbourne, NY 12788
Phone: 845.434.2086 • Fax: 845.434.2087

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Medical Consent Form

Camper First Name: _____ Middle: _____ Last: _____

Who should be contacted in case of an emergency? (Please list two and then **check the box next to the primary contact**)

Full Legal Name: _____ Relationship: _____

Phone #: _____ Address: _____

Full Legal Name: _____ Relationship: _____

Phone #: _____ Address: _____

Please detail any special circumstances/conditions that we should be aware of to assist us in the care of your child: _____

IMPORTANT

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

PLEASE NOTE

Camp has a supply of commonly found over-the-counter medications. If you feel there is a need to send along a personal supply, please have your child bring it to the infirmary for safe keeping on the day of arrival. State law prohibits the possession of any medications (prescription, vitamin, herbal, as needed (e.g. ibuprofen), over the counter) on campgrounds (**this law applies to everyone - even those who are 18 and above**).

Insurance Information

I do not have **Medical Insurance**. I am responsible to pay all medical fees incurred.

I do not have **Drug Coverage**. I am responsible to pay for all medication costs.

Please provide a copy of the **front and back** of the insurance card when returning this form.

› Does your insurance cover dental work? Yes No

Name of Insured: _____ Relationship to Camper: Self Parent Other: _____

Camper Legal Name: _____ Member ID: _____ Group #: _____

DOB: ____/____/____ SS#: ____-____-____ RX Group #: _____ RX PCN #: _____ RX BIN #: _____

Name of Insurance: _____ Phone Number: _____

Address: _____

City

State

Zip Code

Department of Health regulations require the following authorizations for your child to attend a sleepaway camp.

For campers under 18; fill in their full legal name in the space provided and then a legal guardian must sign below. For campers 18 and above, fill in "N/A" and then the camper should sign below.

I, the undersigned, do hereby authorize Camp Oraysa or any authorized representative thereof, as my agent to act in my name, place and stead in any way in which I could act, if I were personally present and capable, with respect to myself, if incapacitated physically, mentally, or otherwise, and _____, whether or not incapacitated, as the case may be, including, without limitation, consent to any diagnostic procedures or medical care which is deemed advisable by, and is to be rendered under the general or special supervisions of any licensed physician and surgeon at any hospital or doctor's office, regardless where the diagnosis or treatment is rendered. 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. It is understood that the above authorizations will only be used in an emergency. Every attempt will be made to contact a legal guardian before the authorizations are used. This authorization shall remain in effect through July 13th, 2021, unless sooner revoked in writing delivered to said agent(s).

I, the undersigned, will notify the camp if said minor is exposed to any communicable disease or has had recent injury or medical issue. If said minor has a chronic medical condition, it is important that the camp be notified.



Signature _____

Date _____