LUBAVITCH EDUCATIONAL CENTER

בס"ד

PIONEERS DIVISION
JULY 1 - AUGUST 9, 2019

APPLICATION FORM

Camper's Name	Hebrew Name	Date of Birth	School	Grade Entering	Weeks Attending *Please circle*
		/ /			1 2 3 4 5 6
		/ /			1 2 3 4 5 6

Family Name: _____ Father's Name:_____ Mother's Name: _____

Address: _____ City: _____State: _____ Zip: _____

Phone: _____ Cell: _____ Work: _____

Fax: _____ email: _____

In the event of an emergency call: _____Relation: _____ Phone: _____

My son is allergic to: _____

Doctor's Name: _____Phone: _____

Health Insurance Co. _____ Policy #: _____

CAMP FEE: $275.00/Week
REGISTRATION FEE: $25.00 per child
For further information: Rabbi Yakov Garfinkel at ygarfinkel@lecfl.com

Form of Payment: ☐ Weekly/CASH ONLY ☐ Single Check Payment Accepted Only if Made for Entire 6-Weeks

By registering my son in the Pioneers Division, I am permitting him to go on all outings included in the camp program.

Signature: _____

MEDICAL INFORMATION	Yes	No
Does your child have any severe medical problems that we should know about, such as asthma, food allergies (e.g. peanuts, dairy), drug allergies, hearing trouble, epilepsy, diabetes, physical disabilities, etc.? Please specify:		
Should there be any limits on your child's physical activity? Please specify:		
Has your child had any serious illness in the past three years? Please specify:		
At the present time, is your child under a doctor's care? Please specify:		
Can your child swim?		
Is your child currently taking any medications? Please specify:		
Can we contact your doctor for medical reports? Doctor: _____ Hospital:_____ Telephone: _____		
Is your child covered by medical insurance? Insurance Co.: _____I.D. #:_____ Telephone: _____		
When was the last time your child had a physical examination? Date: _____ Doctor: _____ Telephone: _____		
Please list any other information you consider important for us to know:		

I do hereby authorize the performance of medical examinations and necessary treatments (including drugs, X-rays, tests, etc.) as may be deemed advisable or necessary by an attending physician. This consent shall be in effect for the period of time that my child participates in Camp Gan Israel activities. If an emergency arises requiring a major surgical procedure, I understand that the Camp Director will make every effort to contact me and be guided by my wishes. In the event that I cannot be reached, I authorize the attending physician to act as medical judgment may dictate.

Parent or Guardian's signature: _____ Date: _____

MEDICAL CONSENT FORM

Dear Parent/Guardian,

Your son is below legal age of consent. Florida law requires that we have your permission if medical service is needed. Your signature on the Consent Form will authorize us to proceed with the care of lesser types of medical issues that arise. In the event of serious health issues, we will notify you as promptly as possible and follow your instructions. If we are unable to contact you or your alternative listed number below, your child will be taken to the nearest emergency room and will be treated there.

Camper's Name: _____ Age: _____

Address: _____

City: _____ State: _____ Zip: _____

Date of Birth: _____ Social Security Number: _____

Home Phone: _____ Work Phone: _____

Mobile Phone #1: _____ Mobile Phone #2: _____

Parents' Names: _____

IN CASE OF EMERGENCY AND PARENT OR GUARDIAN CANNOT BE REACHED, PLEASE CONTACT:

#1 - Name: _____ Relationship: _____

Home Phone: _____ Cell Phone: _____

#2 - Name: _____ Relationship: _____

Home Phone: _____ Cell Phone: _____

#3 - Name: _____ Relationship: _____

Home Phone: _____ Cell Phone: _____

TRIP RELEASE FORM

Camper's Name: _____ Age: _____

Parent or guardian should indicate which action should be taken in the event of an emergency:

☐ In the event of an emergency and a parent or guardian is unavailable, I hereby authorize a representative of Camp Gan Israel to make such arrangements as considered necessary for my child to receive medical or hospital care, including transportation. Under such circumstances, I further authorize the physician named below to undertake such care and treatment as considered necessary. In the event such physician is not available, I authorize such care and treatment to be performed by any licensed physician or surgeon.

Physician's Name: _____ Phone: _____

Medical Insurance Co.: _____ Policy #: _____

Patient Insurance ID #: _____

☐ I do not choose the above option and, in the event of an emergency, desire the following action to be taken.

_____

_____

I, the undersigned, agree to bear responsibility for all medical costs incurred on behalf of my son during the camping session, either on or off camp grounds. I also grant permission for my son to participate in all camp activities that take place off of camp grounds, such as, but not limited to, camp trips, late-night activities, overnights and the like.

Parent/Guarding Signature: _____ Date: _____

Camper's Name: _____

Home Phone: _____ Work Phone: _____

Mobile Phone: _____