Participant - First name

Participant - Last name

Participant - Gender

Participant - Date of birth

Participant - Youth Mobile Phone

Participant - Youth Email Address

Participant - Please select one of the following

Israeli Druze

Israeli Jewish

Palestinian Jerusalem Resident (Non Citizen)

Westbank

Other

Please list other choice here

Participant - Email address

School - Grade

School Name

Parent - First name

Last name

Email address

Primary phone Mobile number if available

Employer

Parent2 - First name

Last name

Email address

Primary phone Mobile number if available

Employer

Primary Mailing Address Address Line

Address City

Address State

Address Zip code

Home phone

Emergency Contact

Must be an adult other than a parent/guardian

First name

Last name

Primary phone

Email address

Relationship

Emergency Contact 2 - First Name

Last Name

Phone number

Alternate phone number

Email address

Relationship

Do you have any medical conditions or special needs?

Describe any medical conditions or special needs.

Do you have any allergies?

If yes please describe any allergies?

Do you carry an EpiPen?

Do you carry an inhaler?

Will you need to take any medication during the program?

If yes describe each medication dosage and schedule.

Are there any over the counter medications such as Tylenol or Benadryl that you CAN NOT take?

List any over the counter medications you CAN NOT take.

Are there any activities you cannot physically participate in?

Describe any activities you cannot participate in and why.

Has the participant ever been diagnosed with any of the following medical or behavioral conditions now or in the past?

Check the box next to any of the medical conditions the participant has now or has had in the past.

Asthma

Back problems

Balance problems

Bed wetting

Blood disorder

Broken bones

Bronchitis

Chicken pox

Circulation problems

Constipation

Developmental disabilities

Diabetes

Diarrhea

Digestive disorders

Dizziness during exercise

Ear infections

Epilepsy

Fainting

Frequent colds or sore throats

Head injury concussion

Headaches Migraines

Heart disease

Heatstroke

Hemophilia

Hypertension High Blood Pressure

Kidney problems

Learning disability

Lung disease

Menstrual abnormalities

Nightmares

Seizures

Skin problems

Sleep walking

Stomach upset ulcers

Strokes

Other Describe below

Check the box next to any mental or behavioral health issues the participant has or had in the past.

ADD ADHD

Autism

Depression

Obsessive compulsive disorder

 Bipolar disorder

Anxiety disorder

Substance abuse

Eating disorder

Other

If yes please provide any information about these conditions that may be helpful to camp staff.

Are there any activities or transitions that may cause your child discomfort or anxiety?

In case your child is unwilling or unable to complete or participate in an activity what is the best plan of action?

Insurance - Company name Insurance - Policy number

Which dietary arrangement best meets your needs

Vegetarian

Vegan

Halal (certified)

Kosher (hechshered & prepared in kosher kitchen)

Kosher style (no pork or shellfish) with separate meat and dairy

Kosher vegetarian (hechshered & prepared in kosher kitchen)

No pork but can eat anything else

No special needs

Other (please describe)

Religious background

Muslim

Christian

Jewish

Unitarian Universalist

Druze

Other (describe below)

Describe any religious or dietary needs in detail

Passport ID –

Youth ID Type State ID

ID Number

ID Expiration

Parent One ID Type P

Parent One ID Number

Parent One ID Expiration

Parent Two ID Type

Parent Two ID Number

Two ID Expiration Date

Youth Passport Country

Youth Passport Number

Youth Passport Expiration Date

Do you plan to request a scholarship

T Shirt Size