

UNION FOR REFORM JUDAISM

***B'RIT K'HILAH*—Code of Conduct**

ברית קהילה

I will promote the creation of a religious youth community based on mutual respect and a sense of personal well-being. I will treat others with *kavod* (honor and respect) because we are created *b'tzelem Elohim* (in the image of God). I have read the following rules, designed to promote the health and safety of all event participants, and have indicated my complete acceptance by my signature and that of my parent/guardian.

I will not possess, consume, or distribute alcoholic beverages, other than that served by adult leadership for Jewish sacramental purposes, even if I am of legal drinking age.

I will not possess, use, or distribute any illegal drug or drug paraphernalia.

I will not smoke or consume or distribute tobacco products at any time during the event.

I will attend and participate fully in the entire event, unless otherwise agreed upon with my chaperone. I will arrive on time, stay until the end, and remain on the event premises at all times.

I will not bring or use any weapons, firearms, or anything that may be construed as a weapon.

I will not commit any illegal act. I understand that vandalism, disturbing the peace, or other inappropriate behavior as determined by the adult leadership will not be tolerated. I understand that I will have to pay for any damage that I cause. I understand that no gambling is allowed, except for fundraisers approved by the adult leadership.

I will abide by the event curfew announced by the leadership. After each evening's program, I will go directly to my hotel room, and remain there until breakfast the next morning.

I understand that no guests are allowed at any event and that any unauthorized guests will be asked to leave immediately.

I understand that free time will take place on the main level of the hotel. The only individuals allowed in my hotel room are the ones who have been assigned to sleep in that room.

I will not participate in any activities that could be deemed as hazing, sexually harassing, demeaning, or hurtful.

I agree to refrain from inappropriate sexual behavior.

I agree to abide by any additional rules, pertinent to a specific event, which may be announced, and to accept the consequences of their violation.

I understand that these rules of behavior apply from the time I leave home for the event, during the event itself, and until I return home after the event.

We understand that part of the experience involves activities, group living arrangements and interactions that may be new to my child. These things come with certain risks and uncertainties beyond what my child may be used to dealing with at home. I am aware of these risks, and I am assuming them on behalf of my child. I realize that no environment is risk free and so I have instructed my child on the importance of abiding by *B'rit K'hilah*—Code of Conduct. My child and I both agree that he or she is familiar with these rules and will obey them. We further understand that sanctions imposed by the Adult leadership for violation could include immediate expulsion from the event, at the expense of the parent or guardian.

My signature, and the signature of my parent/guardian, on the attached Health and Safety Form for Unionfor Reform Judaism Youth Programs, affirm my agreement to the rules and policies of this *B'rit K'hilah*.



Health and Safety Form for Youth Programs

The information on this form is gathered to assist us in identifying appropriate care. The more information we have the better able we are to ensure a safe and healthy event. **The form is to be completed by the parents/guardians of participants.**

NO DOCTOR VISIT REQUIRED

Name Last _____ First _____ Middle _____

Home Address Street _____ City _____ State _____ Zip _____ Country _____

Participant E-mail _____ Gender: M F Birth Date _____ Age During Event _____

Participant Phone _____ Participant Cell Phone _____

Custodial Parent/Guardian _____ Home Phone _____ Work Phone _____ Cell Phone _____ E-mail _____ Home Address _____ City _____ State _____ Zip _____ Country _____	Second Parent/Guardian _____ Home Phone _____ Work Phone _____ Cell Phone _____ E-mail _____ Home Address _____ City _____ State _____ Zip _____ Country _____
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EMERGENCY CONTACT INFORMATION If Parent(s)/Guardian(s) are not available in an emergency, please contact:

Name _____ Relationship _____

Home Phone _____ Work Phone _____ Cell Phone _____ E-mail _____

INSURANCE INFORMATION

Is the participant covered by family medical/hospital insurance? Yes No

If so, indicate carrier/plan name _____ Group # _____ Policy # _____

Carrier Address _____

Claims/Phone Authorization # _____ Co-Pay Amount _____

Name of Insured _____ Relationship to Participant _____

PRESCRIPTION PLAN INFORMATION

Name of Insured _____ Insured SS# _____ Relationship to Participant _____

Company Name _____ Group # _____ Policy # _____

Prescription Information # _____ Co-Pay Amount: Generic _____ Brand _____

HEALTH HISTORY

ALLERGIES -

Please describe reaction and management of the reaction.

MEDICATION ALLERGIES

- Penicillin _____
- Amoxicillin _____
- Septra/Cephalosporis _____
- Aspirin _____
- Erythromycin _____
- Sulfa _____
- _____
- _____

FOOD ALLERGIES

- Nuts _____
- Shellfish _____
- Eggs _____
- _____
- _____

OTHER ALLERGIES

- Hay Fever _____
- Ivy Poisoning _____
- Bee Stings _____
- Insect Stings _____
- _____
- _____

PRESCRIPTION MEDICATIONS BEING TAKEN

Please list all prescription medications. Bring enough medication to last the entire time at the event. Keep it in the original packaging bottle that identifies the prescribing physician, the name of the medication, the dosage, and the frequency of administration.

This person takes **NO** medications on a routine basis.

This person takes medications as follows:

Med #1 _____ Dosage _____ Specific times taken each day _____

Reason for taking _____

Med #2 _____ Dosage _____ Specific times taken each day _____

Reason for taking _____

Attach additional pages for more medications or information about side effects.

I give permission to the Camp Health Personnel to dispense any medications as needed. Yes No

OVER THE COUNTER MEDICATIONS BEING TAKEN

My child may be given the following over the counter medications (such as headach relief medicine, cough drops, decongestants, etc.): _____

Please note: You must list all medications that you approve. If a specific OTC medication is not listed above, our staff will not dispense that medication to your child.

RESTRICTIONS

Dietary

- Does not eat red meat Does not eat fish Does not eat eggs Does not eat poultry Does not eat dairy products
- Kosher (please note: Kosher food may not be available) Other (describe) _____

Explain any restrictions to activity (e.g., what cannot be done, what adaptations or limitations are necessary).

GENERAL QUESTIONS - Explain "yes" answers below

		YES	NO			YES	NO
Has/does the participant:							
1.	Had any recent injury, illness or infectious disease?	<input type="checkbox"/>	<input type="checkbox"/>	18.	Ever had treatment for drug/alcohol abuse?	<input type="checkbox"/>	<input type="checkbox"/>
2.	Have a chronic or recurring illness/condition?	<input type="checkbox"/>	<input type="checkbox"/>	19.	Have a history of smoking? If so, how many?	<input type="checkbox"/>	<input type="checkbox"/>
3.	Ever been hospitalized?	<input type="checkbox"/>	<input type="checkbox"/>	20.	Ever had problems with joints (e.g., knees, ankles)?	<input type="checkbox"/>	<input type="checkbox"/>
4.	Ever had surgery?	<input type="checkbox"/>	<input type="checkbox"/>	21.	Have an orthodontic appliance being brought to camp?	<input type="checkbox"/>	<input type="checkbox"/>
5.	Have frequent headaches?	<input type="checkbox"/>	<input type="checkbox"/>	22.	Have any skin problems (e.g., itching, rash, acne)?	<input type="checkbox"/>	<input type="checkbox"/>
6.	Ever had a head injury?	<input type="checkbox"/>	<input type="checkbox"/>	23.	Have diabetes? (Date of onset).....	<input type="checkbox"/>	<input type="checkbox"/>
7.	Ever been knocked unconscious?.....	<input type="checkbox"/>	<input type="checkbox"/>	24.	Have asthma? (Date of onset)	<input type="checkbox"/>	<input type="checkbox"/>
8.	Wear glasses, contacts or protective eye wear?.....	<input type="checkbox"/>	<input type="checkbox"/>	25.	Had mononucleosis in the past 12 months?	<input type="checkbox"/>	<input type="checkbox"/>
9.	Ever had frequent ear infections?	<input type="checkbox"/>	<input type="checkbox"/>	26.	Had problems with diarrhea/constipation?	<input type="checkbox"/>	<input type="checkbox"/>
10.	Ever passed out during or after exercise?.....	<input type="checkbox"/>	<input type="checkbox"/>	27.	Have problems with sleepwalking?	<input type="checkbox"/>	<input type="checkbox"/>
11.	Ever been dizzy during or after exercise?	<input type="checkbox"/>	<input type="checkbox"/>	29.	Have a history of bed-wetting?	<input type="checkbox"/>	<input type="checkbox"/>
12.	Ever had seizures/convulsions?.....	<input type="checkbox"/>	<input type="checkbox"/>	30.	Ever had an eating disorder?	<input type="checkbox"/>	<input type="checkbox"/>
13.	Ever had chest pain during or after exercise?.....	<input type="checkbox"/>	<input type="checkbox"/>	31.	Ever had emotional difficulties for which professional help was sought?	<input type="checkbox"/>	<input type="checkbox"/>
14.	Ever had high blood pressure?	<input type="checkbox"/>	<input type="checkbox"/>	32.	Ever been diagnosed with ADD/ADHD?	<input type="checkbox"/>	<input type="checkbox"/>
15.	Ever been diagnosed with a heart murmur?	<input type="checkbox"/>	<input type="checkbox"/>	33.	Ever been diagnosed with depression	<input type="checkbox"/>	<input type="checkbox"/>
16.	Ever had back problems?.....	<input type="checkbox"/>	<input type="checkbox"/>				
17.	Ever had epilepsy?.....	<input type="checkbox"/>	<input type="checkbox"/>				

Please explain any "yes" answers, noting the number of the question being addressed.

HEALTH AND SAFETY AUTHORIZATIONS
IMPORTANT—THESE BOXES MUST BE COMPLETE FOR ATTENDANCE

Disclosure of Medical Information—Must be signed by Parent/Guardian

I understand that the Union for Reform Judaism is not defined as an entity subject to HIPAA and therefore is not covered by HIPAA regulations concerning patient medical records. I also understand and agree that situations may necessitate that my child's medical information be shared with the event staff and/or event medical staff. I give permission to any Health Care Provider, such as a hospital or physician to share my child's medical information with the event medical staff, for treatment purposes.

Signed Printed Date

Health and Safety—Must be signed by Parent/Guardian

Health and Safety This health history is correct and complete to my knowledge. The person herein described has permission to engage in all program activities except as noted. I hereby give permission to the Union for Reform Judaism to provide routine health care, administer prescribed medications and seek emergency medical treatment including ordering x-rays or routine tests. I agree to the release of any records necessary for insurance purposes. I give permission to the Union to arrange necessary related transportation for my child. In the event that I cannot be reached in an emergency, I hereby give permission to the physician/health care provider selected by the Union to secure and administer treatment, including hospitalization, for the person named above. I agree that the Union for Reform Judaism may use any photograph or likeness of my child for Union publicity. This completed form may be photocopied, if needed, for trips off event premises.

Signature of Parent/Guardian _____ Date _____

EVENT PARTICIPATION AUTHORIZATIONS

IMPORTANT—THESE BOXES MUST BE COMPLETE FOR ATTENDANCE

To be read and signed by Parent or Guardian

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Signature of Parent/Guardian _____ Date _____

To be read and signed by Parent or Guardian

Event transportation I give my permission for my son/daughter to be driven to and from the event by authorized vehicle (bus or automobile) transportation. I understand that my son/daughter may not drive to or during the event. I agree to indemnify and hold harmless the Union for Reform Judaism, their employees, volunteers, and members from any harm which may come to my son/daughter while driving to or from the event. I also am aware that it is the responsibility of my son/daughter to notify the Union office of his/her transportation arrangements to and from the event when this information becomes available.

Signature of Parent/Guardian _____ Date _____

To be read and signed by Union for Reform Judaism Participant

B'rit Kehillah—Code of Conduct I have read the *B'rit Kehillah—Code of Conduct* and I understand that these rules of behavior apply from the time I leave home for the event, during the event itself, and until I return home after the event.

Signature of Participant _____ Date _____

PHOTO/VIDEO RELEASE—To be read and signed by Parent or Guardian

I give my permission to the Union for Reform Judaism to use any video or photograph, either online or in print, or any video taken at the event my child is attending for the purpose of marketing or promoting the Union and its programs.

Signature of Parent/Guardian _____ Date _____

IMPORTANT—
Please notify us if this participant has been exposed to any communicable disease during the three weeks prior to attendance of this event.