UNION FOR REFORM JUDAISM
האיחוד ליהדות רפורמית
SERVING REFORM CONGREGATIONS IN NORTH AMERICA

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__________	**Second Parent/Guardian**__________
Home Phone _____ **Work Phone** _____	**Home Phone** _____ **Work Phone** _____
Cell Phone _____ **E-mail** _____	**Cell Phone** _____ **E-mail** _____
Home Address __________	**Home Address** __________
City _____ **State** _____ **Zip** _____ **Country** _____	**City** _____ **State** _____ **Zip** _____ **Country** _____

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 headached 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

Has/does the participant:

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

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________