

**Baltimore Educational Initiative for Teens of Reform Judaism**  
**BEIT-RJ**  
**2010-2011/5770-5771 School Year**  
**Confidential Health History And Medical Information Form**  
**To Be Completed Each Year For All Students, New & Returning**

Student's Name \_\_\_\_\_  
*Last* *First* *Middle*

Gender: \_\_\_\_\_ Male \_\_\_\_\_ Female      Date of Birth: \_\_\_\_\_

Secular School Attended: \_\_\_\_\_ Grade this Fall: \_\_\_\_\_

**EMERGENCY CONTACT INFORMATION**

Custodial Parent/Legal Guardian: \_\_\_\_\_

Home Phone: \_\_\_\_\_ Cell Phone: \_\_\_\_\_ Work Phone: \_\_\_\_\_

Second Parent Parent/Legal Guardian: \_\_\_\_\_

Home Phone: \_\_\_\_\_ Cell Phone: \_\_\_\_\_ Work Phone: \_\_\_\_\_

Alternate Emergency Contact in the case that a parent/guardian cannot be reached  
(must be over 18 years of age)

Name: \_\_\_\_\_ Relationship to Student: \_\_\_\_\_

Home Phone: \_\_\_\_\_ Cell Phone: \_\_\_\_\_ Work Phone: \_\_\_\_\_

**HEALTH & DENTAL INSURANCE INFORMATION**

Health Insurance Carrier/Plan: \_\_\_\_\_

Telephone Number: \_\_\_\_\_ Group # \_\_\_\_\_ Policy# \_\_\_\_\_

Name of Policy Holder: \_\_\_\_\_ Relationship to Student: \_\_\_\_\_

Dental Insurance Carrier/Plan (if different from health insurance): \_\_\_\_\_

**MEDICATIONS** (List all medications, including over-the-counter or non-prescription drugs, taken routinely by the student. Give the purpose for which each medication is taken and the side effects, any.)

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(CONTINUE ON REVERSE)

**ALLERGIES**

Medications (e.g., penicillin, sulfa, amoxicillin, etc.) \_\_\_\_\_

Food (e.g., nuts, wheat, eggs, etc.) \_\_\_\_\_

Other (e.g., hay fever, insect stings, mold, dust, etc.) \_\_\_\_\_

**HEALTH HISTORY**

	<b>Yes/No</b>	<b>If yes, Please Explain</b>
Recent injury, illness, infectious disease	_____	_____
Chronic or recurring illnesses or conditions	_____	_____
Glasses, contacts, or protective eye wear	_____	_____
Hearing or speech problems	_____	_____
Chronic nosebleeds or nose problems	_____	_____
Seizures or convulsions	_____	_____
Back or orthopedic problems	_____	_____
Drug or alcohol abuse	_____	_____
Orthodontic appliance brought to school	_____	_____
Diabetes	_____	_____
Asthma	_____	_____
Emotional difficulties requiring professional help	_____	_____
Learning Disabilities (such as ADD/ADHD)	_____	_____
Other	_____	_____

**AFFIRMATION**

**My affirmation below confirms that this Health History and Medical Information form is true and complete. The student has my permission to engage in all school activities except as noted otherwise. The school has my permission to provide routine first aid, administer prescribed medications at my request, and seek emergency medical or dental treatment. If the student is not covered by medical and/or dental insurance, I agree to pay all costs incurred for emergency treatment. In the event of a medical or dental emergency, the school may transport the student for treatment. In the event of an emergency where none of the adults listed above are available, I authorize and give my consent to the school to obtain any necessary medical or dental treatment, including hospitalization and surgery, from a licensed health care provider or facility. This form may be photocopied for school-sponsored trips or retreats.**

Signature of Custodial Parent of Legal Guardian: \_\_\_\_\_

Print Name: \_\_\_\_\_

Date Signed: \_\_\_\_\_