

Baltimore Educational Initiative for Teens of Reform Judaism
BEIT-RJ
2011-2012/5771-5772 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.)

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

	Yes/No	If yes, Please Explain
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: _____