

THE UNITED SYNAGOGUE OF CONSERVATIVE JUDAISM FAR WEST REGION USY/KADIMA MEDICAL HISTORY

DATE _____

SYNAGOGUE/CHAPTER _____

TO THE PARENTS: The information on this form will be kept strictly confidential with access only to the Regional Staff and Certified Medical Personnel. Each USYer (including Kadimaniks) must file a medical history with the Regional Office every September. **It is the responsibility of the parent to notify the Regional Office of any changes that may occur after the history is submitted.**

USYer / Kadimanik _____ Birth Date _____ Sex _____ E-Mail _____

Parent/Guardian _____ Phone _____

Home Address _____
Street and Number _____ City, _____ State, _____ Zip _____

Business Address _____ Phone _____
Street and Number _____ City, State, Zip _____

Emergency Contact _____ Phone _____

RELATIONSHIP TO USYER _____

Health History

Please check each line that applies and give vaccination dates where applicable:

Chicken Pox _____	Date _____	Anorexia _____	Diphtheria _____	Herpes _____
German Measles _____	Date _____	Asthma _____	Emotional Counseling _____	Hypertension _____
Measles _____	Date _____	Bleeding/Clotting Disorder _____	Frequent Ear Infections _____	Hypoglycemia _____
Mumps _____	Date _____	Convulsions _____	Gastro Intestinal _____	Kidney/Urinary _____
Polio _____	Date _____	Diabetes _____	Hayfever _____	Mononucleosis _____
Tetanus _____	Date _____	Digestive _____	Heart Defect/Disease _____	Other _____

Disability, chronic/recurring illness, or operations: _____

List all medications currently taken on a regular basis and reasons for taking: _____

Explain all other medical problems or conditions of which we should be aware: _____

Describe any recommendations or restrictions of which we should be aware: _____

List any allergies to food, drugs, plants, insects, etc.: _____

MEDICAL INSURANCE*

***OUR POLICY IS THAT NO ONE UNDER THE AGE OF 18 MAY PARTICIPATE IN OUR PROGRAM WITHOUT PROOF OF MEDICAL INSURANCE COVERAGE, INCLUDING COMPANY NAME, POLICY NUMBER, ETC.**

Medical Insurance Co.: _____ Policy/Group# / Medical Record # : _____

Insurance Company Address _____
Street Number _____ City _____ State _____ Zip _____

Insurance Company's Phone #: _____

Personal Physician Name: _____ Phone#: _____

THE INFORMATION ON THIS FORM IS ACCURATE, COMPLETE AND ALL-INCLUSIVE, TO THE BEST OF MY KNOWLEDGE. I UNDERSTAND THE IMPORTANCE OF KEEPING THIS INFORMATION ACCURATE AND AGREE TO CONTACT THE REGIONAL DIRECTOR PRIOR TO ANY REGIONAL PROGRAM THAT MY CHILD WILL ATTEND IF THERE IS A CHANGE OF ANY KIND WHATSOEVER IN HIS/HER MEDICAL CONDITION.

USYer/Kadimanik's Parent/Guardian

Date

USYer/Kadimanik's Parent/Guardian

Date