



Rabbi Joel E. Soffin Founder
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BONIM BANIM: BUILDING YOUTH HEALTH AND SAFETY FORM

Health and Safety Form for Bonim Banim

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 is required).**

Teen's name _____ Sex: M _____ F _____

Home address Street _____

City _____ State _____ Zip _____ Teen's cell _____

Birthdate _____ Age during event _____

Parent's name _____ Parent's home phone _____

Parent's work phone _____ Parent's cell phone _____

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

Please list insurance information: Carrier/plan name _____ Group # _____

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 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 _____

I give permission to the Bonim Banim staff to dispense any medications as needed.

() Yes () No

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Over-the-Counter Medications Being Taken

My child may be given the following over-the-counter medications (such as headache-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.

Allergies - *Please describe reaction and management of the reaction.*

Medication Allergies: please list:

Food Allergies - *Please describe reaction and management of the reaction.*

Other Allergies

Dietary Restrictions

Does not eat red meat Does not eat fish Does not eat eggs

Does not eat poultry Does not eat dairy products

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

The person herein described has permission to engage in all program activities except as noted. I hereby give permission to Bonim Banim 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 Bonim Banim 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 Bonim Banim to secure and administer treatment, including hospitalization, for the person named above.

I agree that Bonim Banim may use any photograph or likeness of my child for publicity.

Signature of Parent/Guardian _____ Date _____