# NJ HAGALIL REGION
# STAFF HEALTH INFORMATION FORM
# 2011 - 2012

**For your safety and protection, this form must be completed so that we can have it on file during Regional events in the 2011-2012 calendar year. In case of emergency, *immediate access* to this information by health providers may be crucial. Please return this form along with your contract.**

**Name_____ Date of Birth_____**

**Address_____City and Zip_____**

**Home Phone _(_____)_____Work Phone_(_____)_____**

**Health Insurance Carrier_____Policy No._____**

**Group No._____ Under whose name is policy?_____**

**In Emergency Notify:**

**Name_____Relationship_____**

**Home Phone_(____)_____Work/Day Phone (____)_____**

**Cell (____)_____**

**This person is authorized by me to select appropriate treatment for me in the event I am unable to do so.**
**Yes_____ No_____**

***Please provide complete information for the questions that follow:***

**Allergies (Medication, Insect, Substance or Food)_____**
**_____**

**Within the past 6 months have you received treatment, been under a doctor's care or taken medication for any illness, injury or condition? (If yes, give details_____**
**_____**

**Within the past 6 months have you been hospitalized for any reason? (If yes, give details) _____**
**_____**

**Do you have any chronic/recurring illness or disability? (If yes, please explain)_____**
**_____**

**Please list any medications (including dosage and frequency) you are now taking and reason(s) _____**
**_____**

**Please advise us of any other health related information about which a physician or heatlh provider should be aware_____**
**_____**

***THIS FORM HAS TWO SIDES***

**Please describe any personal restrictions, limitations or modifications (activity, diet etc.) while attending the Regional Program:**_____

_____

_____

**Date of last Tetanus Booster**_____

***For female staff:*** **Are you in any stage of pregnancy? Yes____No____Unsure____**

**The above information is correct and complete to the best of my knowledge.**

## AUTHORIZATION

**In the event of medical emergency, accident or health problem where immediate treatment is deemed necessary and in the event that a) I am unable to select an appropriate course of treatment and b) the individual I have authorized above to select treatment on my behalf cannot be reached after a reasonable effort, I hereby give permission to the physician(s) selected by the Regional Kadima Director or Regional Youth Director to hospitalize, secure proper treatment, order injection, anesthesia or surgery or provide any medical care deemed appropriate for me by said physician(s). I understand that information on this form may be released to our Health Providers and Insurance Carriers in the event medical treatment is rendered. When deemed necessary (as described above), this form may be photocopied for use off the site of the Regional event.**

**SIGNATURE**_____**DATE**_____

## HAGALIL USY/KADIMA
## Staff Code

**I have read the enclosed policies of the United Synagogue and I am familiar with them. By signing this application, I attest to the fact that I fulfill the requirements stipulated and agree to abide by the policies established by the International Youth Commission.**

_____

**Signature**

_____

**Please print your name here**

## PLEASE RETURN THIS COMPLETED FORM TO:

**Kadima/USY**
**1090 King Georges Post Road**
**Suite 1003**
**Edison, NJ 08837**

**<u>This Form Has Two Sides</u>**