MEDICAL FORM

(This information will be kept strictly confidential.)

Name of Student:_____

Father's Name: _____ Mother's name: _____

Parents are married ☐ divorced ☐ separated ☐ widowed ☐

Address: _____

Phone no.: _____ Date of Birth: _____

Passport no.: _____ Place of Birth: _____

PERSON IN ISRAEL TO NOTIFY IN CASE OF EMERGENCY:

Name: _____ Relationship to Student: _____

Address: _____ Phone: _____

1. Are you a vegetarian, vegan or do you have any special dietary requirements? _____

_____

2. Height: _____ Weight: _____

3. Have you or any member of your family suffered from: tuberculosis, epilepsy, emotional disturbances, heart diseases, asthma, diabetes, digestive tract diseases, other diseases. Please check appropriate answer below. If yes, give details. Use separate sheet, if necessary. ( ) NO ( ) YES Details: _____

_____

_____

4. Please list any hospitalizations and diagnosis: ( ) NO ( ) YES Details and dates:

_____

5. Have you ever received psychological counseling: ( ) NO ( ) YES Details:

_____

6. Are you allergic to any medications: ( ) NO ( ) YES

If yes, indicate which medications: _____

7. List any other allergies: _____

8. Have you ever suffered from an eating disorder? ( ) NO ( ) YES Details:

_____

MEDICAL EXAMINATION TO BE COMPLETED BY PHYSICIAN

Student: ____

1. Vision: ____________________ Hearing: ______________
2. General Examination

General Examination	Normal	Deviation from Normal
Height	______	______________
Weight	______	______________
Heart	______	______________
Lungs, Chest	______	______________
Blood Pressure	______	______________
Hemoglobin	______	______________
Abdomen, Digestive Tract	______	______________
Mouth, Throat	______	______________
Skin	______	______________
Spine	______	______________
Feet	______	______________
Nervous System	______	______________
Allergies	______	______________
Menstrual History	______	______________

Other remarks: ____

____

3. a) Is student presently receiving any medications? Is so, please attach statement of such medications with dosage and directions.
   b) List any medication that the student has taken regularly at any point over the last three years.

   ____

   ____

4. Does the student have any history of an eating or dietary disorder, or currently manifest any signs of either? ( ) NO ( ) YES

Details: ____

5. Does the student have any physical limitations: ( ) NO ( ) YES

   Details: ____

6. Date of last tetanus immunization: ______________________________

I have examined the above named student and DO consider her physically and emotionally able to participate in your program in Israel.

Name of Physician (please print): ______________________________

Address: ______________________________ Phone: ______________

Date: ______________ Signature: ______________________________

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To the best of my knowledge, all the above information is both accurate and complete.

Student Signature ______________________________