

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	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: _____

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

Student Signature _____