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 and dates:
_____

6. Are you allergic to any medications: ( ) NO ( ) YES
If yes, indicate which medications:_____

7. List any 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 the student presently receiving any medications? If 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 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:_____