MEDICAL EXAMINATION TO BE COMPLETED BY PHYSICIAN

(This information will be kept strictly confidential.)

Name of Student:_____ Phone no:_____ Date of Birth:_____

Address:_____

1. Has the student 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: _____

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

3. Has the student ever received psychological counseling: ( ) NO ( ) YES Details:
_____
_____

4. Is the student allergic to any medications: ( ) NO ( ) YES
If yes, indicate which medications: _____

5. List any other allergies: _____

6. Is the student vegetarian, vegan or have any special dietary requirements? _____

7.

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		
Vision		
Hearing		

Other remarks: _____

8.

a. Is 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.

____

____

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

Details: ____

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

Details: ____

11. 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 ____