Confidential: Medical Examination Form for applicant:

Given Name:_____ Surname:_____

INFORMATION ON MEDICAL EXAM

Each student needs to supply a complete and up to date medical certificate issued by a hospital or medical center recognized by the Israeli Embassy.

The certificates should be signed and have an official seal of the doctor.

Not only should this certificate show the general health and wellness of the student (including height, weight etc.) but also show that the student has been tested for chronic or infectious diseases as required by the Israeli ministry of health:

the certificate should state that the student has been checked and has been certified medically and physically fit.

It should confirm that the student has no underlying medical, physical problem or mental problem and has no existing chronic diseases.

It should also state if the student has any allergies or is taking medication on a regular basis All

statements must be correct and accurate.

Any student who has been found to have falsified statements will be requested to return home at once, at their own expense and be required to pay the full cost of the tuition.

NOTES TO THE EXAMINING PHYSICIAN

The demanding environment and strenuous activities students will encounter will push their physical and mental abilities. Therefore, a complete medical report is crucial to ensure the health and safety of all applicants.

This form should be completed by the applicant's primary physician.

Additionally, any applicant with a history of specialist care must submit a detailed report from the specialist, including diagnosis, prognosis, and evaluation.

If medication is required during the program, a separate medical letter with complete details is necessary. Since brand names of medications may differ, please include the full pharmacological name of all prescribed drugs.

Any changes in an applicant's health within 10 days before departure require a full explanatory letter detailing diagnosis, prognosis, and treatment. Failure to submit this letter may result in program exclusion.

Please date and stamp each page of the medical report.

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PERSONAL HEALTH HISTORY (To be Completed by Physician & Applicant)

Male Female

First Name: _____ Surname:_____
Passport Number: _____ Birth Date: ___/___/
Home Address: _____
Country: _____ Phone:_____
Email: _____
Name: _____ P h o n e :_____

IMPORTANT: in case of emergency, please notify:
Name _____ Phone:_____
Relationship to Participant: _____

Medical HISTORY (Answer "Yes" or "No")

Allergies:
Do you suffer from any anaphylaxis / Life-threatening allergic reactions? Yes/ No
If yes please elaborate:
_____
_____

Penicillin: Yes / No

Other medicine: Yes / No
Please elaborate:
_____

Food Allergies: Yes / No
Please elaborate:

_____

Asthma: Yes / No
Bronchitis: Yes / No
Chicken Pox: Yes / No
Convulsions: Yes / No
Color Blindness: Yes / No
Diabetes: Yes / No
Drug Use: Yes / No
Ear Infections: Yes / No
Eating Disorders: Yes / No
Epilepsy: Yes / No
Eye Trouble: Yes / No
Fainting: Yes / No
German Measles: Yes / No

Headaches: Yes / No
Heart Trouble: Yes / No
Kidney Trouble: Yes / No
Measles: Yes / No
Mumps: Yes / No
Pneumonia: Yes / No
Poliomyelitis: Yes / No
Rheumatic Fever: Yes / No
Scarlet Fever: Yes / No
Sleepwalking: Yes / No
Thyroid Disorders: Yes / No
Tuberculosis: Yes / No
Venereal Disease: Yes / No
Chronic medication Yes / No

IMMUNIZATION/VACINATIONS

Covid19: Yes / No *If yes please elaborate:*
Brand: _____
Doses: _____ Date of last Vaccination: __/___/___
Whooping Cough: Yes / No
Date of last immunization: ___/___/___
Tetanus: Yes / No
Date of last immunization: ___/___/___
Polio Vaccine: Yes / No
Date of last immunization: ___/___/___

TINE (TB) Test: Negative /Positive
Date of last immunization: _/_/_ DTP: Yes / No
Date of last immunization: ___/___/___
MMR: Yes / No
Date of last immunization: ___/___/___
Hepatitis B Yes / No
Date of last immunization: ___/___/___
Varicella (Chicken Pox) : Yes / No
Date of last immunization: ___/___/___

Clear Date and stamp please

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IMPORTANT:

1) Please give all details concerning any allergies and anaphylaxis /life-threatening allergic reactions to which "Yes" is answered above, including details of medications required.

_____

_____

_____

2) Has the applicant ever suffered any chronic or recurring illness? If Yes, give details and provide a specialist's letter.

_____

_____

_____

3) Has the applicant undergone any operation or sustained serious injuries? If Yes, give details including name and address of attending physician.

_____

_____

_____

4) Is the applicant taking any medication now? If so, please specify the name of medication(s) and condition being treated.

_____

_____

_____

BLOOD TESTS RESULTS

Name of Test	Results	
HIV		please include the result page
CBC		
Venereal Disease panel		

All sections must be filled out completely and will be handled confidentially.

Clear Date and stamp please

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Name of Applicant: _____

PHYSICAL EXAMINATION (To be completed by licensed physician)

	Normal	Abnormal	Describe Abnormality
Head			
General Build			
Neck			
Ears			
Eyes * Mention if the applicant uses spectacles			
Teeth			
Mouth, Throat			
Chest, Lungs			
Heart			
Vascular System – B.P.			
Abdomen and Viscera			
Hernia			
G.I. System			
Upper Extremities			
Lower Extremities			
Spine			
Skin, Lymphatic's			
Nervous System			

Weight: _____
Height: _____
Blood Type: _____
Blood Pressure: _____
Pulse: _____

Hearing: _____
Vision: _____
Color Vision:_____
Any abnormal findings: _____
_____
_____

For Female participants:
Pregnant: Yes/No
Gynecological abnormalities: Yes / No

HAS THE APPLICANT SUFFERED ANY OF THE FOLLOWING:

Cancer:	☐	Hepatitis C:	☐	Thyroid Disorder:	☐	Hepatitis A:	☐
Hepatitis B:	☐	Scarlet Fever:	☐	German Measles:	☐	Mumps:	☐
Pneumonia:	☐	Epilepsy:	☐	Measles:	☐	Other:	
Chicken Pox:	☐	Kidney condition:	☐	Tuberculosis	☐		

If ticked, please give further details:

_____

_____

_____

Clear Date and stamp please

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Mental Health

Is the applicant currently involved in psychological therapy of any kind? Yes / No

If so: With whom? Psychiatrist ☐ Psychologist ☐ Counselor ☐ Social Worker ☐

Is the individual receiving any medication? Yes / No

If so, specify: _____

_____

_____

Is there any history of psychological or psychiatric care? Yes / No

If so, specify: _____

_____

_____

Has the applicant ever been advised to have counseling, psychotherapy or psychiatric care? Yes / No

_____

Has the applicant ever been hospitalized for psychiatric care? Yes / No

_____

Additional comments _____

_____

_____

_____

_____

_____

_____

Clear Date and stamp please

Confidential: Medical Examination Form

PHYSICIAN'S STATEMENT

I have read the "Notes to the Examining Physician" on page one of the Medical Form and thereafter have examined _____ whom I have known for _____ years.

The results I have recorded represent, to the best of my knowledge, all the applicant's medical history and my findings on examination. I understand that the program organizers in Israel will rely on my report and findings.

In my opinion the applicant is physically, mentally and emotionally capable of participating in the program as outlined in the Notes.

I recommend full physical activity: Yes ☐ No ☐

If not, please describe. _____

_____

I recommend certain restrictions: Yes ☐ No ☐

If yes, please describe. _____

Name of Physician: _____ **Name of Hospital**_____

Address _____

Phone: _____ Email:_____ Date ___/___/_____

_____	_____	_____
Signature of Physician	License Number Stamp	Official Hospital

APPLICANT'S STATEMENT

I hereby certify that, to the best of my knowledge, this medical form is complete in all its details and fully realize that any condition, mental or physical, that I am found to have, originating prior to my arrival in Israel, and which is not described in full in this form or in any accompanying letter, will be due cause for my return to my country of origin, or treatment in Israel solely at my expense, and that the Program has neither responsibility nor liability arising out of such condition.

I also realize that medical coverage does not include dental treatment, or eyeglasses. All medication that I take regularly is at my own expense and has been detailed in this form or letters. I also give my full permission for all treatment of any nature deemed necessary by doctors in Israel to be extended to me within the framework of the Medical Services of the program in Israel. I also acknowledge the fact that usage of, or involvement with, alcoholic beverages, drugs or narcotics, or any other anti-social behavior, may be cause for dismissal from the program and that I will be responsible for all expenses resulting from such involvement and dismissal.

Name:_____ Signature_____

Date: ___/___/_____

Clear Date and stamp please