Yeshivat Ateret Yerushalayim

MEDICAL FORM

(This information will be kept strictly confidential)

Name of Student____

Address____

Phone # __________________Date of Birth____/____/____Passport #_________________

Father's Name_______________________Business Phone__________________________

Mother's Name______________________Business Phone__________________________

Person in Israel to notify in case of emergency (if applicable):

Name_____________________________Relationship____________________________

Address____Phone _________________

1. Height___________________________Weight_____________________________

Please check the appropriate answers below. If the answer to any question is "yes", please give details. Use a separate sheet if necessary.

2. Have you or any member of your family ever suffered from: Tuberculosis, Epilepsy, Emotional Disturbances, Heart Disease, Asthma, Diabetes, Digestive Tract Diseases, or other diseases? ( )No ( )Yes , Details.

   ____

3. Have you sustained any injury or undergone any surgery? ( )No ( )Yes,Details:

   ____

4. Have you ever received psychological counselling? ( )No ( )Yes, Details:

   ____

5. Please list any hospitalizations and diagnosis. ( )N/A ( )Yes, Details:

   ____

6. Are you allergic to any medications? If so, indicate which. ( )No ( )Yes, Details:

   ____

7. List any other allergies____

MEDICAL EXAMINATION TO BE COMPLETED BY PHYSICIAN

Student's Name_______________________________________

1. Vision:________________________________Hearing:_____________________________

2. General examination:

Item	Normal	Deviation from normal
Heart		
Lungs, Chest		
Blood Pressure		
Hernia		
Hemoglobin		
Abdomen, Digestive Tract		
Mouth, Throat		
Skin		
Spine		
Feet		
Nervous System		
Allergies		

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. Has the student manifested any signs of an eating/dietary/digestive disorder? ( )No ( )Yes, Details:____

5. Does the student have any physical limitations? ( )No ( )Yes, Details:_________

____

6. Date of last tetanus immunization:

____

7. Has the student at any time been diagnosed as having a learning disability? ( )No ( )Yes, Details____

____

I have examined the above and consider him physically and mentally able to participate in your program in Israel.

Name of Physician (please print) ____

Address____Phone_____________________

Signature_________________________________Date________________________________