If you have already submitted an online medical form through the 'applytosem' website, you must still complete this medical history form and have it signed by your physician.

Please note that students who do not complete a medical history form **will not be permitted to join the program**. Medical forms must be submitted to mtehillah@nevey.org no later than June 13 2019.

# MEDICAL HISTORY FORM

This questionnaire is strictly confidential and will become part of your medical record.

| | |
|---|---|
| **Student Name:** | **DOB:** ***(dd/mm/yy)*:** |
| **Passport Number:** | **Home Telephone Number:** |
| **Family Address:** | |
| **Family Physician:** | **Telephone Number:** |

## PERSONAL HEALTH HISTORY

**Childhood illness:** ☐ Measles ☐ Mumps ☐ Rubella ☐ Chickenpox ☐ Rheumatic Fever ☐ Polio ☐ Infectious Mononucleosis ☐ Hepatitis

| **Immunizations and dates:** | | |
|---|---|---|
| | ☐ Tetanus | ☐ Pneumonia |
| | ☐ Hepatitis | ☐ Chickenpox |
| | ☐ Influenza | ☐ MMR *Measles, Mumps, Rubella* |
| | ☐ Polio | ☐ Measles |

| | |
|---|---|
| Recurrent Strep Throat | Eye Problems |
| Respiratory Disorders | Ear Problems |
| Intestinal Disorder | Sinus Problems |
| Urinary Tract Disorders | Neurological Disorders |
| Heart Disease | Psychiatric Disorder |
| Blood Disorders | Dermatological Disorders |
| Skeletal Disorders | Gynecological Disorders |
| Kidney Disease | Other |

**List any medical problems that other doctors have diagnosed**

| |
|---|
| |
| |
| |

**Surgeries**

| Age | Reason | Hospital |
|---|---|---|
| | | |
| | | |
| | | |

**Other hospitalizations**

| Year | Reason | Hospital |
|---|---|---|
| | | |
| | | |
| | | |
| | | |

**List your prescribed drugs and over-the-counter drugs, such as vitamins and inhalers**

| Name the Drug | Strength | Frequency Taken |
|---|---|---|
| | | |
| | | |
| | | |

**Allergies to medications**

| Name the Drug | Reaction You Had |
|---|---|
| | |
| | |

| | |
|---|---|
| | |

**PHYSICAL EXAMINATION (describe details in space below)**

| HEIGHT | | WEIGHT | | PULSE | | BLOOD PRESSURE | | VISUAL ACUITY R | | L | |
|---|---|---|---|---|---|---|---|---|---|---|---|

| | Normal | Abnormal | | | Normal | Abnormal |
|---|---|---|---|---|---|---|
| **Skin** | | | | **Abdomen** | | |
| **Ears** | | | | **Liver/Spleen** | | |
| **Hearing** | | | | **Hernia** | | |
| **Teeth** | | | | **Extremities** | | |
| **Tonsils** | | | | **Back** | | |
| **Glands** | | | | **Genitalia** | | |
| **Heart** | | | | **Menses** | | |
| **Lung** | | | | | | |

Has the applicant ever been diagnosed, counseled or treated for a learning or reading disability? Give details:

______________________________________________

______________________________________________

______________________________________________

Has the applicant received psychological/psychiatric counseling?

______________________________________________

______________________________________________

______________________________________________

Do you have any recommendations or precautions with respect to diet, swimming, diving, hiking or strenuous activities?

______________________________________________

______________________________________________

______________________________________________

## PHYSICIAN'S STATEMENT

*I have examined ______________________________ and DO / DO NOT consider her physically and/or emotionally qualified to participate in an overseas program in Israel. I certify that the above statements are true and complete to the best of my knowledge.*

_____________________________________ ________________________

***Physician's signature*** ***Date***

**APPLICANT'S STATEMENT** *(please read before signing)*

*I fully realize that any condition, mental or physical, that I am found to have originating prior to my arrival in Israel, which is not described in full in this form or any accompanying letter, will be due cause for my return to my country of origin or treatment in Israel, solely at my expense.*

*I also acknowledge the fact that usage or involvement with alcoholic beverages, drugs or narcotics or any other anti-social behavior may be cause for immediate dismissal from the program, with no refunds given, and that if I am dismissed from the program, I will be returned to my country of origin at my own expense.*

**NAME OF APPLICANT:________________________________ Date:________________________**

Applicant's Signature:____________________________________