



MEDICAL EXAMINATION TO BE COMPLETED BY PHYSICIAN

Student : _____

Height: _____ Weight: _____

1. Vision: _____ Hearing: _____

2. General Examination	Normal	Deviation from Normal
Heart	_____	_____
Lungs, Chest	_____	_____
Blood Pressure	_____	_____
Hernia	_____	_____
Hemoglobin	_____	_____
Abdomen, Digestive Tract	_____	_____
Mouth, Throat	_____	_____
Skin	_____	_____
Spine	_____	_____
Feet	_____	_____
Nervous System	_____	_____
Allergies	_____	_____
Menstrual History	_____	_____

Other remarks: _____

3. a) Is the student currently 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 disorder?

() NO () YES Details:

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

6. Date of last tetanus immunization : _____

I have examined the above named student and DO consider him/her physically and emotionally able to participate in your program in Israel

Name of Physician (please print): _____

Address: _____

Date: _____ Signature: _____

To the best of my knowledge all the above information is both accurate and complete
Student Signature _____

Applicant's name _____
(please print) Last First

Prescription / Non prescription Medications

If your child is not on any prescription medications please go straight to the next page- Part B.

A. Prescription Medication

Please fill out one of these forms for EACH medication. You may use the back of the form if more room is needed.

Please provide us with as much information as possible pertaining to your child's medications as it can be a direct effect on the success of your child in the program.

1 a. What is the name and dosage of the medication you child is currently taking?

b. How often? What time of day does your child take this medication _____

c. Does it say the same thing on the bottle? If no, please explain: YES____NO ____

d. What is the medication for (what is it supposed to do)?

e. Who prescribed the medication? _____

f. How long has your child been on the medication for? _____

g. Does the medication interact with other medications or something else?

h. Does the medication have any side effects that your child experiences?

2.a. How does your child take the medication? _____

b. Is it taken independently? Or is a reminder needed? _____

c. Has the medication ever purposely not been taken _____

3. What is the procedure if a dose is missed? _____

4. What is your plan for filling the medication during your child's year in Israel?

(Are you sending replacement, are we filling the prescription- does it have refills on the bottle or are you sending a prescription?) _____

Applicant's name _____
(please print) Last First

B. Non- prescription medications

The better prepared we are even for the 'little' things, the more we can be of assistance to your child throughout her year and help her gain the utmost from all of her experiences.

1. Does your child get sick often?

Headaches, stomach aches, menstrual cramps, colds, coughs, or other...

2. What do you suggest your child should do when he/she is not feeling well?

3. What medications does your child take for the above listed ailments?

4. Do you give your child aspirin, Tylenol, Advil? Which seems to have the best effect?

5. Can your child swallow pills, or if not how does he/she take medication?

For Girls Only:

6. What happens when your daughter has her period? Does she need medication?

Mood? PMS ? Cleanliness? Etc.

7. Other information you think we should know:
