AIM Healthnet Center
15 Kanfei Nesharim Givat Shaul, Jerusalem Tel: (02) 653-7111 Fax: (02) 653-7099

MEDICAL HISTORY FORM

Student Name ____________________ _______________ __________
Last name *First* *Mid*

Birthdate: [ ] Month [ ] Day [ ] Year

Passport No: ____________________ **Social security No**. ____________________

Family Address ______________________ ____________________ _____________ ____________
Address City State
Zip

Telephone _______________ _______________ _______________ _______________________
Home Work Fax
E-mail

Present School ______________________________ **Yeshiva** ________________________________
Last School attended
attending in Israel

Family Physician ______________________________ **Telephone** ______________________________

Person to contact in emergency: ________________________ **Telephone** _______________________

IMMUNIZATION RECORD (CIRCLE No.)

DPT	**1 2 3 4 5**	**DATE OF LAST TETANUS IMMUN.**	____________________
OPV	**1 2 3 4 5**	**DATE OF LAST TETANUS IMMUN.**	____________________
MEASLES	**(DATE)**	**DATE OF LAST TETANUS IMMUN.**	____________________
MUMPS	**(DATE)**	**HEPATITUS VACCINE A** ____________ **B**	____________
RUBELLA	**(DATE)**	**MENININGOCOCCAL VACCINE**	____________________
		OTHER	____________________

PAST MEDICAL HISTORY (HAS STUDENT HAS ANY OF THE FOLLOWING? CHECK AND DESCRIBE DETAILS IN SPACE BELOW.)

MEASLES _____ **RUBELLA** _____ **MUMPS** ______ **CHICKEN POX** ______ **HEPATITIS** _____
INFECTIOUS MONONUCLEOSIS _____ **EATING DISORDER** _____ **ANOREXIA** _____ **BULEMIA** _____

RECURRENT STREP THROAT	____________	**EYE PROBLEMS**	____________
RESPIRATORY DISORDERS	____________	**EAR PROBLEMS**	____________
INTESTINAL DISORDERS	____________	**SINUS PROBLEMS**	____________
URINARY TRACK DISORDERS	____________	**RHEUMATIC FEVER**	____________
NEUROLOGICAL DISORDERS	____________	**HEART DISEASE**	____________
PSYCHIATRIC DISORDERS	____________	**BLOOD DISORDERS**	____________
DERMATOLOGICAL DISORDERS	____________	**SKELETAL DISEASE**	____________
GYNECOLOGICAL DISORDERS	____________	**KIDNEY DISEASE**	____________
ALLERGIES (FOOD, MED, ETC.)	____________	**ASTHMA**	____________
ACNE		**OTHER (explain below)**	____________

DESCRIBE DETAILS: ____
____
____

LIST BELOW ANY HOSPITALIZATION AND/OR SURGERY THE STUDENT HAS HAD.

AGE OR DATE	PROBLEM OR OPERATION

PHYSICAL EXAMINATION (DESCRIBE DETAILS IN SPACE BELOW)

HEIGHT ________ **WEIGHT** ________ **PULSE** ________ **BLOOD PRESSURE** ____________

VISUAL ACUITY. . . . R ____________ **L** ____________

	NORMAL	ABNORMAL		NORMAL	ABNORMAL
SKIN			ABDOMEN		
EARS			LIVER/SPEEN		
HEARING			HERNIA		
TEETH			EXTREMITIES		
TONSILS			BACK		
GLANDS			GENITALIA		
HEART			MENSES		
LUNGS			OTHER		

MEDICATIONS (INCLUDE DOSAGE) ____________

HAS THE APPLICANT RECEIVED PSYCHOLOGICAL/PSYCHIATRIC COUNSELING? YES NO
IF YES, *PLEASE SPECIFY BELOW* AND INCLUDE A LETTER FROM THE TREATING DOCTOR.
HAS THE APPLICANT BEEN DIAGNOSED, TREATED OR COUNSELED? YES NO
(IE: EATING DISORDERS, ADHD, LEARNING DISABILITIES, ETC.)? IF YES, *PLEASE SPECIFY BELOW* AND HAVE THE TREATING THERAPIST FORWAD A LETTER WITH PERTINENT DETAILS.

DO YOU HAVE ANY RECOMMENDATIONS OR PRECAUTION WITH RESPECT TO DIET, SWMMING, DIVING, HIKING OR STRENOUS ACTIVITIES?

PHYSICIANS STATEMENT

I HAVE EXAMINED ____________ AND DO/DO NOT CONSIDER HIM/HER PHYSICALLY AND/OR EMOTIONALLY QUALIFIED TO PARTICIPATE IN AN OVERSEAS STUDY PROGRAM IN ISRAEL.
HE/SHE CAN/CANNOT PARTICIPATE IN AN INTENSIVE WORKOUT PROGRAM.
I CERTIFY THAT THE ABOVE STATEMENTS ARE TRUE AND COMLETE TO THE BEST OF MY KNOWLEDGE.

____________	____________	____________
PHYSICIANS SIGNATURE	**PHONE NO.**	**DATE**

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PATENTAL DECLARATION AND CONSENT FOR EMERGANCY MEDICAL TREATMENT

I HAVE REVIEWED THIS FORM AND DICLARE THAT TO THE BEST OF MY KNOWLEDGE THE INFORMATION GIVIN IN IT IS A FULL DISCLOSURE, ACCURATE AND TRUTHFUL.

I HEREBY GIVE AUTHORITY AND CONSENT TO THE SCHOOL AND AIM TO OBTAIN NECESSARY MEDICAL TREATMENT AND/OR ACT ON BEHALF OF MY SON/DAUGHTER AND RELEASE HEALTH INFORMATION WITH UNDERSTANDING THE FAMILY WILL BE NOTIFIED AS SOON AS POSSIBLE.

____________	____________	____________
SIGNATURE OF PARENT OR GUARDIAN	**PHONE NO.**	**DATE**