

STUDENT NAME: _____ BIRTHDATE: _____
 Last name First Mid. Month Day Year

PASSPORT NO: _____ SOCIAL SECURITY NO. _____

FAMILY ADDRESS: _____
 Address City State Zip Country

TELEPHONE: _____
 Home Work Cell

PARENT EMAIL _____ STUDENT EMAIL _____

YESHIVA ATTENDING IN ISRAEL: _____

FAMILY PHYSICIAN: _____ TELEPHONE: _____

EMERGENCY CONTACT: _____ 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)	_____	HEPATITIS VACCINE:	A	_____	B	_____	
MUMPS (DATE)	_____	MENINGOCOCCAL VACCINE	_____				
RUBELLA (DATE)	_____	OTHER	_____				

PAST MEDICAL HISTORY

(Has student had 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 TRACT 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) _____				

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

AGE / DATE:

PROBLEM / 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/SPLEEN	_____	_____
HEARING	_____	_____	HERNIA	_____	_____
TEETH	_____	_____	EXTREMITIES	_____	_____
TONSILS	_____	_____	BACK	_____	_____
GLANDS	_____	_____	GENITALIA	_____	_____
HEART	_____	_____	MENSES	_____	_____
LUNGS	_____	_____	OTHER	_____	_____

MEDICATIONS (INCLUDE DOSAGE) _____

- HAS THE APPLICANT EVER BEEN DIAGNOSED, COUNSELED OR TREATED? (INCLUDING LEARNING ISSUES ,EATING DISORDERS ETC) IF YES, PLEASE SPECIFY _____
- HAS THE APPLICANT EVER RECEIVED PSYCHOLOGICAL/ PSYCHIATRIC TREATMENT? IF YES, PLEASE SPECIFY AND INCLUDE A LETTER FOR THE TREATING DOCTOR _____
- DO YOU HAVE RECOMMENDATIONS OR PRECAUTIONS WITH RESPECT TO DIET, ALLERGIES, HEALTH, PHYSICAL OR STRENUOUS ACTIVITIES? _____

PHYSICIAN'S 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 COMPLETE TO THE BEST OF MY KNOWLEDGE.

PHYSICIAN'S SIGNATURE

PHONE NUM.

DATE

PARENTAL DECLARATION AND CONSENT FOR EMERGENCY MEDICAL TREATMENT

I HAVE REVIEWED THIS FORM AND DECLARE THAT TO THE BEST OF MY KNOWLEDGE THE INFORMATION HEREIN 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 NUM.

DATE