JOINT YESHIVA APPLICATION - STUDENT MEDICAL INFORMATION

This information will be kept strictly confidential

To document your health status, please provide a complete immunization record, medical history and evidence of a recent physical examination. **These documents need to be submitted before you are given your place in a dormitory setting.** Your doctor must validate the following forms with his/her signature and valid license number.

LAST NAME: _____ FIRST NAME:_____ DOB: _____

FULL ADDRESS: _____

PARENTS' PHONE: HOME_____ MOBILE_____ STUDENT PASSPORT _____

Parental permission: parental consent should be obtained to provide medical treatment, prescribe or dispense medications or perform procedures on persons under age 18. A parent or legal guardian should sign this consent form so that such treatment may be administered promptly and unnecessary delay avoided. Note: Except in a dire emergency, no operative procedure will be performed without parental notification and additional consent.
I give permission for such diagnostic, therapeutic or emergency operative procedure as may be necessary to evaluate and treat

*(Name of Applicant)*_____

*Parent/Guardian (print)*_____ *Relationship*_____

*Parent/Guardian (sign)*_____*Date*_____

TO BE FILLED OUT BY PHYSICIAN
PLEASE MAKE A COMPLETE EXAMINATION AND INDICATE YOUR FINDINGS

HEIGHT _____ _____ % WEIGHT: _____ ____ % BMI _____BP_____ HR_____ EKG_____

ITEM	FINDINGS	ITEM	FINDINGS
SKIN		ABDOMEN	
EYES		GENITALIA	
EARS		LYMPH NODES	
NOSE		NERVOUS SYSTEM	
THROAT		MUSCULOSKELETAL	
LUNGS		NECK/THYROID	
HEART		URINALYSIS	

Has applicant had surgery, been hospitalized, been seen in the emergency room or seen a specialist in the past five years? If so, please specify:

_____

_____

Has the applicant had any of the following? If YES, please give the dates. If the applicant CURRENTLY has any of the following, please write YES and give the details in the space provided below, and/or on a separate page.

ASTHMA BRONCHITIS PNEUMONIA		FOOD ALLERGY ---------- SKIN ALLERGY	----------	HEPATITIS (TYPE)	
DIABETES TYPE I ---------- DIABETES TYPE II	----------	DRUG ALLERGY If yes, please list drug and type of reaction	.	EAR PROBLEMS SINUS INFECTION	

IBD/OTHER INTESTINAL PROBLEMS		KIDNEY PROBLEMS		MIGRAINE OR OTHER HEADACHES	
CELIAC DISEASE		HAY FEVER		H.I.V	
HERNIA		MALIGNANCY		EPILEPSY	
CARDIO-VASCULAR PROBLEMS		CHICKEN POX SHINGLES		MUSCULO-SKELETAL PROBLEMS	
POLIO		MEASLES		RHEUMATIC FEVER	
WHOOPING COUGH		GERMAN MEASLES		APPENDICITIS	
MUMPS		DOES PATIENT SMOKE?		SLEEP WALKING	

If you answered YES to any of the items in this section, please provide details:_____

_____

_____

VACCINATIONS (Please give dates. An immunization record may be attached)

HEPATITIS A: 1st shot:_____ 2nd shot: _____

HEPATITIS B: 1st shot:_____ 2nd shot: _____ 3rd shot: _____

POLIO VACCINE: dates of immunizations and type: _____ MMR _____

TETANUS BOOSTER _____ PERTUSSIS BOOSTER _____ DIPHTHERIA BOOSTER _____

GAMMABLOBULIN _____ ____ OTHER IMMUNIZATIONS _____

T.B.: latest test date _____ result:_____ If positive, date of chest X-ray:_____

Result:_____ Was prophylaxis given? _____ Dates: from _____ to _____

Has student had Meningococcal Meningitis immunization? Date received_____

IMPORTANT: Has applicant had psychological counseling/therapy? Is there a history of weight loss/eating problems? Details:

_____

_____

Emotional equilibrium, the ability to get along with others and easy group adjustment are all factors important in a program such as this one. Does the applicant have a problem which will endanger the health, welfare or enjoyment of the other group members?

_____

_____

Is the applicant receiving any medication? If YES, please indicate type/generic name of medication with dosage and directions, and reason for this need: _____

_____

_____

I have known the applicant for ____ year(s). I believe that the applicant is able to study in Israel and participate in all activities, which include workout/weight room, swimming, diving, hiking, and all athletic sports, with the following recommendations:

_____

_____

I have not willfully or knowingly withheld or misrepresented any pertinent medical information.

Date of examination _____Name of physician_____

Signature _____, M.D.

Emergency telephone number: _____ License Number _____

Address: _____ City, State, Zip _____