



Bnei Akiva Hachshara

Medical Form

This form will be treated as confidential. Please complete the form with a black pen in block capitals. Use additional sheets if necessary.

First names _____ Family name _____

Father's name _____ Mother's name _____

Parents are: married divorced separated widowed

Full address _____

_____ Zip/post code _____

Country _____

Home phone _____

Date of birth _____ Place of birth _____

Passport number _____ Expiry date _____

Person in Israel to notify in case of emergency:

Name _____ Relationship to applicant _____

Address _____ Telephone _____

1. Vegetarian Vegan Other dietary requirements _____

2. Height _____ Weight _____

3. Have you or any member of your family suffered from: tuberculosis, epilepsy, emotional disturbances, heart diseases, asthma, diabetes, digestive tract diseases, or any other diseases? Yes No

If "yes", please give details: _____

4. Please list any hospitalizations and diagnoses: _____

5. Have you ever received psychological counseling? Yes No

If "yes", please give details: _____

6. Are you allergic to any medications? Yes No

If "yes", please give details: _____

7. List any other allergies: _____

If your allergy may require special attention, please attach a letter to this medical form with full details.

8. Have you ever suffered from an eating disorder? Yes No

If "yes", please give details: _____

MEDICAL EXAMINATION TO BE COMPLETED BY A PHYSICIAN

Full name: _____

	Normal (✓)	Deviation from normal
Vision		
Heart		
Lungs and chest		
Blood pressure		
Hernia		
Hemoglobin		
Abdomen and digestive tract		
Mouth and throat		
Skin		
Spine		
Feet		
Nervous system		
Allergies		
Menstrual history		

Other remarks: _____

Allergies: _____

Is the candidate presently receiving any medications? Yes No

If 'Yes', please attach statement of such medications with dosage and directions.

List any medication that the candidate has taken regularly at any point over the last three years:

Has the candidate manifested any signs of an eating / dietary disorder? Yes No

Details: _____

Does the candidate have any physical limitations? Yes No

Details: _____

Date of last tetanus immunization: _____

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

Name of physician (please print and stamp) _____

Address _____ Telephone _____

Date _____ Signature _____

To the best of my knowledge, all the above information is both accurate and complete.

Candidate's signature _____