

Participant Health History

Please make sure you complete all sections (a-e)

This form must be signed by a state-licensed, Medical doctor (see section e)

A. Applicant's personal details	
Last name:	First name
Date of Birth (mm/dd/yyyy):	Gender: M/F

B. Parent or Guardian details:			
Last name:		First name:	
Tel:	Cell phone:	Zipcode:	
Home Address	Number:	Street:	City:
State:	E-mail:		

C. In case of emergency details:			
Last name:		First name:	
Tel:	Cell phone:	Zipcode:	
Home Address	Number:	Street:	
City:	State:	Email:	
Is there anyone else we can contact in case of emergency?			
Is there anyone in Israel we can contact in case of emergency?			

Declaration of health – Please answer the following yes/no, checking the appropriate box and adding details where relevant.

Question	Yes	No	Details
1. Has the applicant been hospitalized at any time?			
2. Has the applicant suffered at any time from heart disease, cancer, cerebral disorder, nervous disorders or any other health condition?			
3. Has the applicant at any time required to have an operation?			
4. Has the applicant at any time suffered from any form of disability?			
5. Has the applicant suffered from any mental illness?			
6. Is the applicant aware of any current or past health conditions?			
7. Is the applicant on medication for any disorder?			



Personal declaration

I hereby declare that I am not suffering from any illness or accident. I am not handicapped. I am not undergoing any medical treatment of any kind. I do not, nor have in the past suffered from any chronic conditions (such as heart disease, high blood pressure, disability, etc) a congenital disability, or malignant disease. I am bit aware of any need for medical treatment, hospitalization or surgery

Signed. _____ Date _____

If you have responded "yes" to one or more of the above questions, please provide necessary details, write the date of the event referred and the condition. Then please sign the declaration below and return this form.

Signed. _____ Date _____

Physician declaration

I have examined Mr. / Miss _____ and have, to the best of my knowledge, noted the applicants medical history and findings on examination.

In my opinion the applicant is capable of participating in the summer program outlined in the notes.

I have known the applicant for _____ years.

Physician name: _____

Physician signature: _____

Address: _____

Phone: _____