בס"ד

MEDICAL HISTORY FORM

Surname:		Given Name:			
Child's Address:					
Child's Place of Birth:					
Mother's Full Name:					
Phone	H:		W:	M:	
Father's Full Name:					
Phone	H:		W:	M:	
Family Doctor's Name:					
Phone					
Family Dentist or Orthodontist Name:					
Phone					
Any special dietary requirements?	☐ No ☐ Yes	If yes, provide details			
If necessary, can your child be given Panadol, Nurofen, Sudafed or other non-prescription medications?			☐ No	☐ Yes	
Does your child have any diagnosed medical / emotional / psychological condition?			☐ No	☐ Yes	
If yes, provide details					
Does your child take medication for any diagnosed condition?			☐ No	☐ Yes	
If yes, provide details					

TO BE COMPLETED BY MEDICAL PRACTITIONER

This section of the form is to be completed and signed by a registered medical practitioner who has known the applicant for at least the past year. All sections must be filled out completely by the physician and will be treated confidentially.

Notes to the Examining Physician

The strenuous environment each participant will face taxes his/her physical and mental capabilities to the fullest. It is therefore imperative, as a safeguard to the health of the participant, that this report be as complete and precise as possible. Any applicant who has been under the care of a specialist (for example, cardiologist, neurologist, psychiatrist, psychologist, social worker, etc.) must submit a written detailed report from this specialist giving complete diagnosis, prognosis and evaluation.

If a participant is required to continue receiving medication while under the auspices of the program, he/she should include a medical letter giving full details. Since very often medicine is not available under the same trade name as in the country of origin, the full pharmacological name of all medicines and drugs used by the patient should be given. In any event, participants should bring an extra supply of the required medicine with him/her, some of which should be entrusted to the group leader.

If any changes take place in the participant's condition within the last ten days before departure, the participant must submit, before departure, an explanatory medical letter detailing diagnosis, prognosis and treatment.

For Your Information

1. **Social Environment**: Most participants will be living in a communal environment. They will be sleeping in a shared living quarters with other people and eating in communal dining facilities.
2. **Activity**: The participants will be expected to participate in extensive tours of the country, which will include walking long distances, climbing, hiking and other strenuous activities.
3. **Medical facilities**: The physician should also bear in mind that medical facilities available for participants will cover only acute illnesses and accidents. There are no facilities available for the treatment for chronic disturbances. Medical care will very often be entrusted to fully trained para-medical personnel, although a doctor will always be available and on call, as will the local hospital. In some cases, the patient will be transferred to Jerusalem for specialized medical treatment when necessary, and, where indicated, will later be returned to the country of origin for further treatment.

KTC Israel Experience Student's Name: _____

Has the student had the following vaccinations?			**Are they up to date?**	
Immunisations	☐ Yes	☐ No	☐ Yes	☐ No
Triple Antigen	☐ Yes	☐ No	☐ Yes	☐ No
Polio	☐ Yes	☐ No	☐ Yes	☐ No
Tetanus (required every 7-10 years	☐ Yes	☐ No	☐ Yes	☐ No
Date of last vaccination. It is essential to be up to date				
Measles	☐ Yes	☐ No	☐ Yes	☐ No
Mumps	☐ Yes	☐ No	☐ Yes	☐ No
Rubella	☐ Yes	☐ No	☐ Yes	☐ No
Hepatitis A / B	☐ Yes	☐ No	☐ Yes	☐ No

Is the Student Allergic to:				
Allergy	☐ Yes	☐ No	**Reaction**	**Action Taken**
Drug allergies				
Penicillin	☐ Yes	☐ No		
Sulfas	☐ Yes	☐ No		
Other	☐ Yes	☐ No		
Non-Drug allergies				
Hayfever	☐ Yes	☐ No		
Dust / Pollen	☐ Yes	☐ No		
Bee Stings	☐ Yes	☐ No		
Milk / Dairy Products	☐ Yes	☐ No		
Other	☐ Yes	☐ No		
Current Health				
Asthma	☐ Yes	☐ No		
Diabetes	☐ Yes	☐ No		
Epilepsy	☐ Yes	☐ No		
Migraines	☐ Yes	☐ No		
Arthritis	☐ Yes	☐ No		
Ear Infections	☐ Yes	☐ No		
Throat Infections	☐ Yes	☐ No		
Back Problems	☐ Yes	☐ No		
Other	☐ Yes	☐ No	*If other, specify:*	

Past Illnesses			
Chicken Pox	☐ Yes	☐ No	
Measles	☐ Yes	☐ No	
German Measles	☐ Yes	☐ No	
Mumps	☐ Yes	☐ No	
Hepatitis	☐ Yes	☐ No	
Glandular Fever	☐ Yes	☐ No	
Does the Student Have?			
Glasses	☐ Yes	☐ No	
Contact Lenses	☐ Yes	☐ No	
Hearing Difficulties	☐ Yes	☐ No	
Speech Difficulties	☐ Yes	☐ No	
Other?	☐ Yes	☐ No	*If other, specify:*
Has the Student had any of the following Operations?			
Appendix	☐ Yes	☐ No	
Tonsils	☐ Yes	☐ No	
Other	☐ Yes	☐ No	*If other, specify:*

Other Important Conditions

Is the Student Required to carry an EpiPen? ☐ Yes ☐ No

Details:

Note: EpiPen are not readily available in Israel and we recommend your child brings two (2).

Has the student suffered any chronic recurring illness or any other significant ill health during the last five years? If YES, give details and include a letter from the specialist detailing the student's current status. ☐ Yes ☐ No

Details:

Has the student ever undergone any operations or sustained any serious injuries? ☐ Yes ☐ No

Details:

Is the student ever currently taking any medications? Provide the name of the condition and the medications below. ☐ Yes ☐ No

Details:

Please specify any problem or disability which may affect a student's participation in activities or medical history of which the Doctor should be informed?

Details

Please specify any psychological condition that may have affected the student in the last 12 months (e.g. depression). Please submit all relevant details.

Details

Has this student been diagnosed with ADHD?	☐ Yes	☐ No
Does this student take medication for ADHD?	☐ Yes	☐ No
Psychological History		
Is the Student currently involved in psychological therapy of any kind?	☐ Yes	☐ No
Details		
Is the Student receiving any medication for a psychological disorder / condition?	☐ Yes	☐ No
Details		
Has the Student ever been advised to have counselling, psychotherapy or other psychiatric care?	☐ Yes	☐ No
Details		
Do you have any other comments or information that you may consider necessary? (e.g. asthma crisis plan)	☐ Yes	☐ No
Details		

Medical Practitioner's Statement

I have read the "Notes to the Examining Physician" on the cover of the examination form and thereafter have examined [Student name:] _____ whom I have known for [Duration] ____. The results I have recorded represent, to the best of my knowledge, all of the Student's medical history and my findings on examination. I understand that the programme organizers in Israel will rely on my report and findings. In my opinion the Student is physically, mentally and emotionally capable of participating in the program as outlined in Notes to the Examining Physician.

I recommend full physical activity	☐ Yes ☐ No	
I recommend certain restrictions	☐ Yes ☐ No	
I recommend a special diet	☐ Yes ☐ No	
Medical Practitioner Name:		
Address:		

Phone:			

Signature		Date:	
		Provider No.	