

MACHON SHOSHANAT YERUSHALAYIM  
**MEDICAL EXAMINATION FORM**

Name of student: \_\_\_\_\_

This part should be filled out by Physician , the next part should be looked over and signed by Physician too.

Name of Physician (please print): \_\_\_\_\_

Physician Address: \_\_\_\_\_

Physician Phone: \_\_\_\_\_ Date: \_\_\_\_\_

1. Vision: \_\_\_\_\_ Hearing: \_\_\_\_\_

Height: \_\_\_\_\_ Weight: \_\_\_\_\_

2. General Examination	Normal	Deviation from Normal
Heart	_____	_____
Lungs, Chest	_____	_____
Blood Pressure	_____	_____
Hernia	_____	_____
Hemoglobin	_____	_____
Abdomen, Digestive Tract	_____	_____
Mouth, Throat	_____	_____
Skin	_____	_____
Spine	_____	_____
Feet	_____	_____
Nervous System	_____	_____
Allergies	_____	_____
Menstrual History	_____	_____

Other remarks: \_\_\_\_\_

3. a) Is student presently receiving any medications? If so, please attach statement of such medications with dosage and directions.

b) List any medication that the student has taken regularly at any point over the last 3 years. \_\_\_\_\_

4. Has the student manifested any signs of an eating / dietary disorder?

No  Yes, Details: \_\_\_\_\_

5. Does the student have any physical limitations?

No  Yes, Details: \_\_\_\_\_

6. Date of last tetanus immunization: \_\_\_\_\_

**This part should be filled out by student and parents**

1.. Have you or any member of your family suffered from : Tuberculosis, Epilepsy, Emotional Disturbances, Heart diseases, Asthma, Diabetes, Digestive Tract Diseases, Other Diseases?

No     Yes, Details: \_\_\_\_\_

2. Do you get depressed easily? \_\_\_\_\_ Have you been depressed in the past? \_\_\_\_\_

3. Have you sustained any serious injury or undergone any surgery?

No     Yes, Details: \_\_\_\_\_

Do you have frequent headaches or migranes? \_\_\_\_\_

4. Please list any hospitalizations and diagnosis : \_\_\_\_\_

5. Have you ever received psychological or psychiatric attention? If yes, please detail: \_\_\_\_\_

6. Are you allergic to any medication?

No     Yes, Details: \_\_\_\_\_

7. Please list any other allergies: \_\_\_\_\_

8. Do you have any eating limitations?

No     Yes, Details: \_\_\_\_\_

Were you in the past absent from school for long periods?

No     Yes, Details: \_\_\_\_\_

**I have examined the above named student and read the personal questioneer, and consider her physically and emotionally able to participate in your program in Israel.**

**Doctors Signature:** \_\_\_\_\_

Please be advised that if it comes to our attention that there were health issues that were not disclosed and brought to our attention, we reserve the right to terminate the sudent's school year.

Parent signiture \_\_\_\_\_

Student signiture \_\_\_\_\_

