בס"ד

AIM Medical Center
15 Kanfei Nesharim
Givat Shaul, Jerusalem
Tel:653-7111 Fax: 653-7099

MEDICAL HISTORY FORM

Passport size PHOTO Required

Student Name _____ _____ _____
Last Name *First* *Mid*

Birthdate: [ ] *Month* [ ] *Day* [ ] *Year*

Passport No: _____ **Social Security No.** _____

Family Address _____
Address *City* *State* *Zip*

Telephone _____ _____ _____ _____
Home Work Fax E mail

Present School _____ **Yeshiva** _____
Last school attended *Attending in Israel*

Family Physician _____ **Telephone** _____

Person to contact in Emergency: _____ **Telephone** _____

IMMUNIZATION RECORD (CIRCLE No.)

DPT 1 2 3 4 5
OPV 1 2 3 4 5
MEASLES (DATE) _____
MUMPS (DATE) _____
RUBELLA (DATE) _____

DATE OF LAST TETANUS IMMUN. _____
DATE OF LAST TETANUS IMMUN. _____
DATE OF LAST TETANUS IMMUN. _____
HEPATITUS VACCINE A _____ **B** _____
MENINGOCOCCAL VACCINE _____
OTHER _____

PAST MEDICAL HISTORY (HAS STUDENT HAD ANY OF THE FOLLOWING? CHECK AND DESCRIBE DEATILS IN SPACE BELOW).

MEASLES _____ **RUBELLA** _____ **MUMPS** _____ **CHICKEN POX** _____ **HEPATITIS** _____
INFECTIOUS MONONUCLEOSIS ___ **EATING DISORDER** ___ **ANOREXIA** ___ **BULEMIA** ___

RECURRENT STREP THROAT	_____	EYE PROBLEMS	_____
RESPIRATORY DISORDERS	_____	EAR PROBLEMS	_____
INTESTINAL DISORDERS	_____	SINUS PROBLEMS	_____
URINARY TRACT DISORDERS	_____	RHEUMATIC FEVER	_____
NEUROLOGICAL DISORDERS	_____	HEART DISEASE	_____
PSYCHIATRIC DISORDERS	_____	BLOOD DISORDERS	_____
DERMATOLOGICAL DISORDERS	_____	SKELETAL DISORDERS	_____
GYNECOLOGICAL DISORDERS	_____	KIDNEY DISEASE	_____
ALLERGIES (FOOD, MED. ETC.)	_____	ASTHMA	_____
ACNE	_____	OTHER (explain below)	_____

DESCRIBE DETAILS: _____

_____

_____

LIST BELOW ANY HOSPITALIZATION AND/OR SURGERY THE STUDENT HAS HAD.

AGE OR DATE	PROBLEM OR OPERATION

ICAL EXAMINATION (DESCRIBE DETAILS IN SPACE BELOW)

HEIGHT _____ WEIGHT _____ PULSE _____ BLOOD PRESSURE _____
VISUAL ACUITY .... R _____ L _____

	NORMAL	ABNORMAL		NORMAL	ABNORMAL
SKIN			ABDOMEN		
EARS			LIVER/SPLEEN		
HEARING			HERNIA		
TEETH			EXTREMITIES		
TONSILS			BACK		
GLANDS			GENITALIA		
HEART			MENSES		
LUNG			OTHER		

MEDICATIONS (INCLUDE DOSAGE) _____

HAS THE APPLICANT EVER BEEN DIAGNOSED OR COUNSELLED OR TREATED FOR A LEARNING OR READING DISABILITY? GIVE DETAILS: _____

HAS THE APPLICANT RECEIVED PSYCHOLOGICAL/PSYCHIATRIC COUNSELING? IF YES, HAVE THERAPISTS FORWARD PERTINENT DETAILS. _____

DO YOU HAVE ANY RECOMMENDATIONS OR PRECAUTIONS WITH RESPECT TO DIET, SWIMMING, DIVING, HIKING OR STRENUOUS ACTIVITIES? _____

PHYSICIANS STATEMENT:

I HAVE EXAMINED _____ AND DO/DO NOT CONSIDER HIM/HER PHYSICALLY AND/OR EMOTIONALLY QUALIFIED TO PARTICIPATE IN AN OVERSEAS STUDY PROGRAM IN ISRAEL. I CERTIFY THAT THE ABOVE STATEMENTS ARE TRUE AND COMPLETE TO THE BEST OF MY KNOWLEDGE.

_____

Physicians Signature Phone No. Date

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PARENTAL DECLARATION AND CONSENT FOR EMERGENCY MEDICAL TREATMENT

I HAVE REVIEWED THIS FORM AND DECLARE THAT TO THE BEST OF MY KNOWLEDGE THE INFORMATION GIVEN IN IT IS TRUE AND ACCURATE.

I DO HEREBY GIVE AUTHORITY TO THE ROSH YESHIVA OR THE ADMINISTRATOR TO OBTAIN NECESSARY EMERGENCY MEDICAL TREATMENT FOR MY SON/DAUGHTER WITH THE UNDERSTANDING THAT THE FAMILY WILL BE NOTIFIED AS SOON AS POSSIBLE.

_____

Signature of Parent or Guardian (Please state) Phone No. Date