FORM D

MEDICAL HISTORY
& PHYSICAL EXAMINATION FORM

**(To be completed by the applicant’s physician no earlier than April 2021
and returned to the Federation office no later than January 9, 2022.)**

NOTES TO PARENT/GUARDIAN(S) AND THE EXAMINING PHYSICIAN:

I. a) **The physical examination needed for participation in the Student Exchange must be completed after April 2021.**

b) **A form generated by the Physician’s office and be completed/signed by a physician will be accepted. The attached Medical History Questionnaire and Physical Examination Form is also acceptable.**

c) If an applicant is required to continue therapy or treatment, or to continue receiving medicines and drugs while under the auspices of the program, (s)he should have 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 must be provided.

d) If any changes take place in the applicant’s condition within the last 10 days before departure, the applicant must submit, before departure, a full, explanatory medical letter, detailing diagnosis, prognosis, and treatment. Failure to submit such letter shall result in expulsion of the applicant from the program without any refund.

II. The information on this medical form and all supplementary letters and reports on the physical, mental, or psychological condition of the applicant shall be held by the Jewish Federation in strict confidence distributed on a need-to-know basis.

IX. Should any participant upon arrival in Israel, or during his/her stay, be found to be suffering from any condition, mental or physical, that was not fully disclosed in this medical form or in an accompanying letter from a qualified medical or psychological professional, then, (1) the participant may at the sole and absolute discretion of the Jewish Federation or its representatives in Israel, be returned to his/her place of origin at the participant’s own expense, or may be treated in Israel, at the participant’s own expense, and there shall be no refund of monies paid for the program, and (2) the Jewish Federation and its representatives in Israel are thereby released of all responsibility or liability of any kind whatsoever arising out of any aspect of such participant’s medical history and mental or physical condition.

Please complete the attached medical history and physical examination form, or a computer generated physical form with the same information, sign and return to:

Student Exchange
Jewish Federation of Greater Ann Arbor
2939 Birch Hollow Drive
Ann Arbor, MI 48108

MEDICAL HISTORY QUESTIONNAIRE

JEWISH FEDERATION of GREATER ANN ARBOR

STUDENT EXCHANGE

(To be completed by a licensed physician **no earlier than April, 2022 and returned to the Federation office no later than January 9, 2022)**

Name of Applicant: ____________________________________ Telephone: ____________________

Address: ____ ______

Number and Street City/State Zip Code

Immunization Record/Dates	**Last Booster/Immunization**
Diphtheria: ____________________	________________________
Whooping Cough: _____________	________________________
Tetanus: _____________________	________________________
Polio (Tri Sabin Oral):___________	________________________
Typhoid (TAB):________________	________________________
German Measles (Rubella):______	________________________
Small Pox: ___________________	________________________
Other (Specify): _______________	________________________

Allergies-	**YES**	**NO**
Hay Fever	____	____
Insect Stings	____	____
Penicillin	____	____
Drugs Allergies	____	____
Food Allergies	____	____
Other (specify)	____	____
______________		
______________		

Communicable Diseases-	**YES**	**NO**
Chicken Pox	____	____
Hepatitis	____	____
Measles	____	____
German Measles	____	____
Mononucleosis	____	____
Mumps	____	____
Polio	____	____
HIV	____	____

Medical History: Check "YES" or "NO." Give approximate DATES for all "YES answers.

	YES	NO		**YES**	**NO**
Abnormal Blood Pressure	________	____	Headaches	________	____
Anemia	________	____	HIV	________	____
Asthma	________	____	Kidney Trouble	________	____
Bronchitis	________	____	Liver Disease (I.e., Jaundice)	________	____
Cancer	________	____	Neurological Disorders	________	____
Chronic Constipation	________	____	Orthopedic Disorders	________	____
Chronic Gastritis	________	____	Circle: Spine Legs Other	________	____
Colitis	________	____	Paralysis	________	____
Convulsions	________	____	Peptic Ulcer	________	____
Diabetes	________	____	Pneumonia	________	____
Dizziness	________	____	Rheumatic Fever	________	____
Ear Infections	________	____	Scarlet Fever	________	____
Epilepsy	________	____	Sinusitis	________	____
Eye Defects	________	____	Sleepwalking	________	____
Fainting	________	____	Thyroid Disorder	________	____
Gynecological Disorders	________	____	Tuberculosis	________	____

Please elaborate on Hepatitis or HIV:

____

____

____

____

Operations: _________________________________

____

____

Serious accidents with residual side effects: _____

____

____

PHYSICAL EXAMINATION

Name: ____

Height: _________ Weight: _________ Blood Pressure: ____________________

Hgb: _____________________________ Urinalysis: _______________________

General Appearance: ____

Hearing: _________________________ Teeth: ___________________________

Eyes: ___________________________ Nose: ____________________________

Abdomen: _______________________ Heart: ____________________________

Throat/Tonsils: ___________________ Hernia: ___________________________

Lungs: ______________________ Posture (Spine): ______________________

Has this person menstruated?: ____

Is menstruation normal?: ____

Describe abnormal findings or handicapping conditions: __________________

____

____

Is there any congenital or other existing condition that may require special treatment or consideration? If yes, please explain. ______________________

____

____

Does this person have a SPECIAL DIET or require SPECIAL MEDICINE?

Detail. ____

____

____

Does this person have a history of EATING AND/OR SLEEPING DISORDERS?

If yes, please explain. ____

Are there any PHYSICAL RESTRICTIONS s to:

Strenuous activity (e.g. hiking): ___________________________________

Physical labor: ____

Other (Specify): ____

To your knowledge, is there any history of mental/psychological or drug/ alcohol related problems? Yes _____ No _____

If yes, please explain: ____

____

I have examined the person herein described and have reviewed his/her health history. It is my opinion that (s)he is physically able to participate in Federation's 2022 Student Exchange and engage in the program's activities except as noted above.

Signature of Examining Physician: ________________________________

Date of examination: ____

Please stamp physician's office information below: