ALL SECTIONS MUST BE FILLED OUT COMPLETELY AND WILL BE TREATED CONFIDENTIALLY

PHYSICAL EXAMINATION

(To be completed by a licensed physician)

	NORMAL	ABNORMAL	DESCRIBE ABNORMALITY
Head			
General Build			
Neck			
Ears			
Eyes			
Teeth			
Mouth, Throat			
Chest, Lungs			
Heart			
Vascular System-B.P.			
Abdomen & Viscera			
Hernia			
G.I. System			
G.U. System			
Upper Extremities			
Lower Extremities			
Spine			
Skin, Lymphatic			
Nervous System			

Weight_____ Height_____ Blood Type_____ Blood Pressure_____
Pulse_____ Respiration_____Hearing_____Vision_____
Any abnormal findings:_____

PSYCHOLOGICAL

1. Is the participant currently involved in psychological therapy of any kind?
   _____
   If so: a) With whom? Psychiatrist____Phychologist____Counsellor____Social Worker_____
2. Is there any history of psychological or psychiatric care? If YES, give dates:
   _____
3. Has the participant ever been advised to have counseling, psychotherapy or other psychiatric care?
   _____
   _____
4. If yes has been answered to any of the above questions, please describe and explain_____
   _____

NOTE TO PHYSICIAN

The program to which the participant is applying is extremely physically and emotionally demanding

PHYSICIAN'S STATEMENT

I have completed an examination of _____ whom I have known for _____years. The results I have recorded represent, to the best of my knowledge, all the participant's medical history and my findings on examination. I understand that the program organizers will rely on my report and findings. In my opinion the participant is physically, mentally and emotionally capable of participating in the program.

I recommend full physical activity: YES_____ NO _____ If NO, please explain:
_____

I recommend certain restrictions: YES_____ NO_____ If YES, please explain:
_____

I recommend a special diet: YES_____ NO_____If YES, please explain: _____
_____

Name of Physician (please print)_____
Address:_____
Telephone: (_____) _____ Date_____

Signature of Physician_____
License Number _____

Physician Stamp

PARTICIPANT'S STATEMENT

I hereby certify that, to the best of my knowledge, this medical form is complete in all its details and I fully realize that any condition, mental or physical, that I am found to have, originating prior to the beginning of the program, and which is not described in full in this form or in an accompanying letter, will be due cause for my return to my country of origin, or treatment in Israel, solely at my expense, and that the program organizers have neither responsibility or liability arising out of such a condition.

All medication that I take regularly is at my own expense, and has been detailed on this form or accompanying letter. I also give my full permission for all treatment of any nature deemed necessary by doctors in Israel to be extended to me within the framework of the Medical Services of the program's organizers in Israel.

Name of participant_____
Date_____