TEL AVIV UNIVERSITY
The Lowy International School

# TAU International Medical Examination Form

*To Be Completed by All TAU International Students*

All students confirmed to study at TAU International are required to complete this form and scan and upload it to the TAU Student Portal within three weeks of program confirmation, regardless of the program or length of study. The information on this form, and any supplementary letters and reports on the physical or mental health condition of the student, are used by TAU International to prepare resources to better facilitate a student's experience and shall be held by TAU as strictly confidential. As this form is intended for information purposes only, the University and its local representatives in North America are released from all responsibility and liability of any kind whatsoever arising out of any aspect of such participant's medical history and mental or physical condition.

This form consists of the following parts:

- **PART I: STUDENT SELF-DECLARATION (REQUIRED)**
- **PART II: HEALTH PROFESSIONAL EXAMINATION FORM (REQUIRED – EXAM MUST BE CONDUCTED WITHIN 6 MONTHS OF PROGRAM ARRIVAL DATE)**
- **PART III: STUDENT STATEMENT AND AUTHORIZATION (REQUIRED)**
- **PART IV: MENTAL HEALTH PROFESSIONAL EXAMINATION FORM (IF RELEVANT - MUST BE COMPLETED WITHIN 6 MONTHS OF PROGRAM ARRIVAL DATE)**

In addition, TAU International students staying for periods longer than 5 months must also complete a Health Insurance Declaration Form which will be made available to students along with instructions for completion.

Students are responsible for notifying TAU International immediately of any changes in health history prior to departure or while on the program. If any changes take place in the student's condition the student must submit a full explanatory medical letter, detailing diagnosis, prognosis, and treatment, and a failure to submit such letter may result in expulsion of the student from his/her program without any refund, at the discretion of the program faculty.

Please be sure to make a copy of the completed health form for your records.

Questions about this form?

- MA Students – Contact your MA Coordinator
- BA/BSC Students – Contact your BA or BSC Coordinator
- Study Abroad and Summer/Short-Term Program Students – Contact admissions@telavivuniv.org if coming from the U.S. or Canada, and intl@tauex.tau.ac.il from anywhere else.

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# PART I: STUDENT SELF-DECLARATION (REQUIRED)

_____

Last Name First Name Middle Name

X_____

Birth Date (DD/MM/YYYY)

_____

Home Address Street City State

_____

Zip (Postal Code) Country

X_____

Mobile Phone (Include Country Code)

X_____

Email Address

I identify my gender as:

- ☐ Female
- ☐ Male
- ☐ Non-Binary
- ☐ Prefer not to disclose
- ☐ _____(fill in the blank)

Students are required to provide a designated **emergency contact**:

X_____

Emergency Contact Name

X_____

Relationship to Participant

X_____

Mobile Phone (Include Country Code)

X_____

Email Address

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Please check "yes" if you have experienced any of the following **diagnoses or symptoms**.
Please give details below on any checked response.

- ☐ Asthma
- ☐ ADD/ADHD
- ☐ Anemia
- ☐ Anxiety
- ☐ Arthritis
- ☐ Autism/Asperger's (ASD)
- ☐ Back Problems
- ☐ Bipolar Disorder
- ☐ Bladder/Kidney Problems
- ☐ Bleeding/Clotting Disorder
- ☐ Blood Disorder
- ☐ Cancer or Leukemia
- ☐ Celiac Disease
- ☐ Cerebral Palsy
- ☐ Depression
- ☐ Diabetes
- ☐ Eating Disorder
- ☐ Epilepsy
- ☐ GI Disorder
- ☐ Head Injury or Concussions
- ☐ Heart Murmur
- ☐ High Blood Pressure
- ☐ Heart Disease
- ☐ Low Blood Pressure
- ☐ Immune System Disorder
- ☐ Impaired Use of Any Limbs
- ☐ Joint Problems
- ☐ Migraines or Severe Headaches
- ☐ Thyroid Disorder
- ☐ Vision/Eye Problems
- ☐ Bronchitis
- ☐ Chicken Pox
- ☐ Dizziness
- ☐ Substance Abuse
- ☐ Ear Infections
- ☐ Fainting
- ☐ Frequent Colds
- ☐ German Measles

_____
_____
_____

Do you have a known or unknown **allergies**?

- ☐ YES
- ☐ NO

IF YES and KNOWN, please check below:

- ☐ Hay Fever
- ☐ Grass
- ☐ Gluten
- ☐ Bees/Wasps
- ☐ Pets/Animal Dander
- ☐ Nuts
- ☐ Penicillin
- ☐ Foods (please specify exactly)_____
- ☐ Medications (please specify exactly)_____
- ☐ Other (please specify exactly)_____

## ADDITIONAL QUESTIONS FOR THE STUDENT

1) Are you currently taking any **medication**? If so, please list:

_____
_____
_____

2) Please comment on any condition(s) above that you checked "yes":

_____
_____
_____

3) Do you have any other **health requirements or dietary restrictions**? If yes, explain.

_____
_____
_____

4) In the last two years, have you received counseling or been treated for a **mental health condition, substance abuse, or eating disorder**? If yes, explain.

_____
_____
_____

5) Do you have **Learning Accommodations** as granted by your pervious or current home university or school? Official documentation of all learning accommodations is required to be uploaded to your TAU Student Portal in order for TAU to consider these. If you have documented learning accommodations that have been honored at your previous home school or university, please indicate yes/no below and any other information you want us to consider in this regard.

_____
_____
_____

6) Is there anything else you think we should know to help you prepare for your experience in Israel? Remember, the more we know the better we are able to be a resource for you!

_____
_____
_____
_____
_____
_____

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# PART II: HEALTH PROFESSIONAL EXAMINATION FORM

**This form should be completed by a primary physician or health care provider with six months of the program arrival date**. In addition, any student who has been under the care of a specialist must submit a written detailed report from such specialist giving complete diagnosis, prognosis, and evaluation.

If a student is required to continue receiving medication while under the auspices of the program, the student 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 and generic names of all medicines and drugs used by the patient should be given.

Please also note that the new and strenuous environment each student will face taxes his/her physical and mental capabilities to the fullest. It is therefore imperative, as a safeguard to the health of the student, that this report be as complete as possible. Things of special note:

- Participants will be living and touring in a sub-tropical climate, with temperatures sometimes reaching over 100 degrees Fahrenheit during the summer (May-October).
- The climate is a mixture of dry semi-arid conditions and humid coastal regions.
- Students will be living in a very close and communal environment. They will be sleeping in a dormitory, sharing living quarters (including bedrooms) with other people.
- Students often participate in extensive tours of the country, which will include walking long distances, climbing and other strenuous activities.

**PHYSICAL EXAMINATION** (To be completed by a licensed physician)

Weight _____ Height _____

Blood Type _____ Blood Pressure _____

Pulse _____ Resp. _____

Hearing _____ Vision _____

Any abnormal findings:

_____

_____

For female participants: Menstrual history –

- ☐ Regular _____
- ☐ Irregular _____

| | Normal | Abnormal |
|---|---|---|
| Head | | |
| General Build | | |
| Neck | | |
| Ears | | |
| Eyes | | |
| Teeth | | |
| Mouth/Throat | | |
| Chest/Lungs | | |
| Heart | | |
| Vascular System – B.P. | | |
| Abdomen and Viscera | | |
| Hernia | | |
| G.I. System | | |
| Upper Extremities | | |
| Lower Extremities | | |
| Spine | | |
| Skin, Lymphatic's | | |
| Nervous System | | |

Describe abnormalities as indicated above:

_____

_____

Please verify the student's most up-to-date **Immunization Record**:

Whooping Cough: Date of last immunization: _____

Tetanus: Date of last immunization: _____

Polio Vaccine: Date of last immunization: _____

TINE (TB) Test: _____ Negative _____ Positive

DTP: Date of last immunization: _____ MMR: Date of last immunization: _____

Hepatitis B Date of last immunization: _____

Varicella (Chicken Pox) Date of last immunization: _____

To your knowledge, is the patient's self-declaration accurate?

- ☐ Yes
- ☐ No, with the following discrepancies: _____

_____

Does the student have any known or unknown **allergy**?

- ☐ Yes (describe in detail below)
- ☐ No

Please give all details concerning any allergy, including details of medications required, names and addresses of physicians, hospitals and consulting specialist. For those with allergies to insect stings, or any anaphylaxis where an injection of epinephrine EpiPen or Epinet Jr. is needed, note this is not easily available in Israel and an additional supply should be taken with the student.

_____

_____

Has the student ever suffered any **chronic or recurring illness**? If yes, give details.

_____

_____

Has the student undergone any **operation** or sustained **serious injuries**? If yes, give details.

_____

_____

Is the student currently taking any **medication** and if so, planning to bring it abroad with them? If so, please specify name of medication(s) and condition being treated.

_____

_____

## MENTAL HEALTH

Is the individual currently involved in **psychological therapy** of any kind? _____

_____

Is the individual receiving any **medication** specifically relating to mental health? If so, specify

_____

_____

Is there any **history of psychological or psychiatric care** or has the applicant ever been advised to have counseling, psychotherapy or psychiatric care? If yes, give dates:

_____

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## HEALTH CARE PROVIDER STATEMENT

The results I have recorded represent, to the best of my knowledge, the entire medical history of the applicant and my findings on examination. I understand that the program organizers in Israel will rely on my report and findings.

In my opinion, the applicant is physically, mentally and emotionally capable of participating in the program as outlined.

- ☐ Yes
- ☐ No
- ☐ I approve full physical activity: Yes No - If no, please explain:

_____

_____

I recommend certain restrictions. Yes- If yes, please explain No

_____

_____

I recommend a special diet. Yes - If yes, please explain No

_____

_____

**Name of Physician** (Please Print) _____

**Address**

_____

Street City State

_____

Zip (Postal Code) Country

**Phone number** ( ) _____ **Date** _____

X_____ X_____

License Number Stamp and Signature of Physician

## PART III: STUDENT STATEMENT AND AUTHORIZATION (REQUIRED)

I hereby certify that, to the best of my knowledge, this medical form is complete in all its details and fully realize that any condition, mental or physical, that I am found to have, originating prior to my arrival in Israel, and which is not described in full in this form or in any 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 is neither responsibility nor liability arising out of such condition. I also realize that medical coverage does not include dental treatment of any form whatsoever, or corrective lenses.

All medication that I take regularly is at my own expense, and has been detailed in this form or letters. 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 in Israel.

I also acknowledge the fact that usage of, or involvement with, alcoholic beverages, drugs or narcotics, or any other anti-social behavior, may be cause for dismissal from the program and that I will be responsible for all expenses resulting from such involvement and dismissal.

X_____

Name of Participant

X_____

Name of Program

X_____

Participant's Signature

X_____

Signature of Parent or Guardian (If under 18 years of age)

Date_____

## PART IV: MENTAL HEALTH PROFESSIONAL EXAMINATION FORM

## (IF RELEVANT)

TO BE COMPLETED BY EITHER CHOSEN EXAMINING PHYSICIAN OR A MENTAL HEALTH PROFESSIONAL (MHP) IF A STUDENT IS UNDER THE CARE OF A SPECIFIC MHP. IF THE LATTER, PLEASE LIST DETAILS OF THE MHP BELOW.

Studying abroad can be an enriching experience as well as a physically and mentally challenging one. Mild or pre-existing health conditions can become serious for some students as they transition into an unfamiliar culture and environment. For this reason, we encourage all students to fully disclose their health history so that we can prepare them properly for their experience, make arrangements for any special accommodations if necessary, and in some cases, assess whether there may be any health reasons that an applicant should consider another program. In order to ensure the applicant's well-being, we expect full disclosure of any health history that could be potentially problematic for a student abroad.

Please give as much detail as possible in answering the following questions. Please include appropriate relevant medical records and any information necessary for medical personnel overseas who might be treating this student.

Is the individual currently under your psychological or mental health care, and will he/she continue such care while abroad in a remote format? Please explain.

_____
_____

Is the individual receiving any medication relating to mental health and wellness? If so, please specify:

_____
_____

Has there any history of psychological or psychiatric care, or past recommendation for such? If yes, give dates:

_____
_____

Has the applicant ever been hospitalized for reasons of mental health?

_____
_____
_____

Additional comments or observations relating to mental health and the specific recommendations for the student's well-being abroad, including a discussed care plan while away:

_____
_____
_____
_____

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**Name of Mental Health Professional** (Please Print) _____

**Address**

_____

Street City State

_____

Zip (Postal Code) Country

**Phone number** ( ) _____ **Date** _____

X_____

**Stamp and Signature of MHP**

**Tel Aviv University | The Lowy International School**
Carter Building, Room 108, Tel Aviv 6997801, Israel
**Tel:** +972-3-640-8118 | **Fax:** +972-3-640-9582
www.international.tau.ac.il