Medical Examination Form

NOTES TO THE EXAMINING PHYSICIAN

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.

This form should be completed by a primary physician. In addition, any applicant 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, he/she 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 should be given.

If any changes take place in the applicant's condition within the last 10 days before departure, the applicant 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 applicant from his/her program without any refund, at the discretion of the program faculty.

FOR YOUR INFORMATION

1) CLIMATE: Participants will be living and touring in a sub-tropical climate, with temperatures reaching 100 degrees Fahrenheit in the shade during the summer. The climate is a mixture of dry semi-arid conditions and humid coastal regions.

2) SOCIAL ENVIRONMENT: Students will be living in a communal environment. They will be sleeping in a dormitory, sharing living quarters with many other people.

3) ACTIVITY: Students will be expected to participate in extensive tours of the country, which will include walking long distances, climbing and other strenuous activities.

4) MEDICAL FACILITIES: The physician should also bear in mind that medical facilities available for students will cover only acute illnesses and accidents. There are no facilities available within the framework of the medical services of the program in Israel for the treatment of chronic disturbances (pre existing conditions). Dental treatment, HIV treatment, pregnancy treatments, eyeglasses, contact lenses and psychiatric treatment are not included and will be arranged at the applicant's expense. A doctor will always be available and on call, as will the local hospital. In some cases, the patient will be transferred to a local hospital for specialized medical treatment when necessary and where indicated will later be returned to the country of origin for further treatment.

PLEASE NOTE

TAU-International I school intends to rely on this completed form and supplementary letters in making determinations of acceptance for or continuation of the student in the program. Omissions or misstatements are at the risk of the student and his/her physician, surgeon, psychiatrist, psychologist, or social worker.

The information on this form, and all supplementary letters and reports on the physical, mental, or psychological condition of the applicant shall be held by TAU as strictly confidential.

Should any participant upon arrival in Israel, or during his/her stay, be found to be suffering from any mental or physical condition, that is not fully disclosed in this medical form or in an accompanying letter from a qualified medical or psychological professional, then:
1) he/she may, at the sole and absolute discretion of the University or its Representatives in Israel or elsewhere, be returned to his/her place of origin at the student's own expense (and there shall be no refund of moneys for the program), and 2) the University and its local representatives in North America are thereby released from all responsibility or liability of any kind whatsoever arising out of any aspect of such participant's medical history and mental or physical condition.

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I. PERSONAL HEALTH HISTORY (To be Completed by Physician & Applicant)

Name: _____ _____ Birth Date: _____
Last First Day Month Year

Home Address: _____
Street City State Zip (Postal Code) Country

Home Phone: ( ) -
_____ ☐ Male

Email:
_____ ☐ Female

Name of Parent or Guardian:_____ Home Phone: ( ) - _____ Work Phone: ( ) - _____

IMPORTANT: If parents are not available in case of emergency, please notify:

Name
_____ Home Phone: ( ) - _____ Work Phone: ( ) - _____

Relationship to Participant: _____

HEALTH HISTORY (Answer "Yes" or "No")

Allergies:
Do you suffer from any anaphylaxis (life-threatening allergic reactions) and food Allergy? Yes/ No - If yes please elaborate :
_____
Penicillin Yes / No: _____
Other:_____

Asthma _____
Bronchitis _____
Chicken Pox _____
Convulsions_____
Diabetes _____
Dizziness _____
Drug Use _____

Ear Infections _____
Eating Disorders _____
Epilepsy _____
Eye Trouble _____
Fainting _____
Frequent Colds _____
German Measles _____

Headaches _____
Heart Trouble _____
Kidney Trouble _____
Measles _____
Mononucleosis _____
Mumps _____
Pneumonia _____

Poliomyelitis _____
Rheumatic Fever _____
Scarlet Fever _____
Sleep Walking _____
Thyroid Disorders _____
Tuberculosis _____
Venereal Disease _____

IMMUNIZATIONS

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: _____

IMPORTANT:

1) Please give all details concerning any allergy to which "Yes" is answered above, including details of medications required, names and addresses of physicians, hospitals and consulting specialist. For those with allergies to insect stings, or any anaphylaxis (life-threatening allergic reactions) and food Allergy? an injection of epinephrine EpiPen auto-injector (for the emergency treatment of anaphylaxis shock) Epinet Jr. is not easily available in Israel and an additional supply should be taken with the applicant.
_____
_____

2) Has the applicant ever suffered any chronic or recurring illness? If Yes, give details and furnish specialist's letter.
_____
_____

3) Has the applicant undergone any operation or sustained serious injuries? If Yes, give details including name and address of attending physician.
_____
_____

4) Is the applicant taking any medication now? If so, please specify name of medication(s) and condition being treated.
_____
_____

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All sections must be filled out completely and will be treated confidentially.

Name of Applicant:_____

PHYSICAL EXAMINATION (To be completed by licensed physician)

	Normal	Abnorm	Describe Abnormality
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			

Weight _____ Height _____ Blood Type _____ Blood Pressure _____

Pulse _____ Resp. _____ Hearing _____ Vision _____

Any abnormal findings: _____

For female participants: Menstrual history – Regular _____ Irregular _____

_____

WHICH OF THE FOLLOWING HAS THE PARTICIPANT HAD:

- □ Cancer
- □ Chicken Pox
- □ Epilepsy
- □ German Measles
- □ Hepatitis A
- □ Hepatitis B
- □ Hepatitis C
- □ Kidney trouble
- □ Measles
- □ Mumps
- □ Pneumonia
- □ Scarlet Fever
- □ Thyroid Disorder
- □ Tuberculosis

Any problems (Please explain): _____

_____

PSYCHOLOGICAL

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

_____

_____

a. If so: With whom? ☐ Psychiatrist ☐ Psychologist ☐ Counselor ☐ Social Worker

b. Is the individual receiving any medication? If so, specify _____

_____

1. Is there any history of psychological or psychiatric care? If yes, give dates: _____

3. Has the applicant ever been advised to have counseling, psychotherapy or psychiatric care? _____

4. Additional comments _____

_____

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PHYSICIAN'S STATEMENT

Full Name of Applicant: _____

I have read the "Notes to the Examining Physician" on page one of the Medical Form and thereafter have examined _____ whom I have known for _____ years. The results I have recorded represent, to the best of my knowledge, all the applicant's medical history 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 in the Notes.

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 _____
Street *City* *State / Province* *ZIP / Postal Code* *Country*

Phone ( ) _____ Date _____
Area Code

X _____ X _____
License Number *Stamp, and Signature of Physician*

APPLICANT'S STATEMENT

I have read the "Notes to the Examining Physician" on page one of the Medical Form. 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 has 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 eyeglasses.

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.

Name of Participant _____ *Name of Program* _____

X _____ X _____ _____

Applicant's Signature *Signature of Parent or Guardian (If under 18 years of age)* *Date*

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The Elite sports Center serves as the venue for all regular university physical education courses as well as intramural, intercollegiate and Israeli league activities. Facilities include an Olympic size swimming pool, a basketball court, a running track, tennis courts and a soccer stadium. The Goldreich Multi-Purpose Sports Building houses fitness and weight rooms, a gymnastics area, and squash courts.

A pass for the elite Sports Centre is available for OSP students. It entitles them to use all the facilities and admission to all activities organized by the Sports Center, such as Israeli folk dancing and outdoor movies at the swimming pool. Admission to the tennis and squash courts is not included in the general pass, but is available for an additional fee.

The fee for the general pass is NOT INCLUDED in your tuition. Individual students can decide to choose this option.

In order to obtain the general pass, you are required to submit a "confirmation of Health" form. The form is not a university policy but a requirement under Israeli law which demands that anyone joining a health club in Israel have a medical confirmation.

While the form can be filled out in Israel, we strongly encourage you to have your doctor sign the form.

ELITE SPORTS CENTRE

Confirmation of Health
TAU INTERNATIONAL

Name of Applicant _____ Passport number _____
Has been examined, found to be in good health and may participate in athletics at Tel Aviv University.

Full Name of Physician _____
Please Print

Address _____
Street *City* *State / Province* *ZIP / Postal Code* *Country*

Phone ( ) _____ Date _____
Area Code

X X

_____ _____
License Number *Signature of Physician*

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