

**THIS SIDE TO BE FILLED OUT BY PARENT**

NAME \_\_\_\_\_ DATE OF BIRTH \_\_\_\_\_ AGE \_\_\_\_\_  
 HOME ADDRESS \_\_\_\_\_ PHONE [HOME] \_\_\_\_\_  
 PARENT OR GUARDIAN \_\_\_\_\_ PHONE [CELL] \_\_\_\_\_

IF NOT AVAILABLE IN CASE OF EMERGENCY [ C"V ], PLEASE CONTACT:

NAME \_\_\_\_\_ RELATIONSHIP \_\_\_\_\_  
 PHONE [H] \_\_\_\_\_ [W] \_\_\_\_\_  
 [CELL] \_\_\_\_\_ ADDRESS \_\_\_\_\_

NAME OF: PHYSICIAN \_\_\_\_\_ PHONE \_\_\_\_\_  
 DENTIST \_\_\_\_\_ PHONE \_\_\_\_\_  
 EYE DOCTOR \_\_\_\_\_ PHONE \_\_\_\_\_

HEALTH INSURANCE CARRIER \_\_\_\_\_ POLICY # \_\_\_\_\_

**AUTHORIZATION FOR TREATMENT :**

I HEREBY AUTHORIZE THE HEALTHCARE PROFESSIONALS SELECTED BY THE TUV HA'ARETZ ADMINISTRATION TO TREAT OR ADMINISTER WHATEVER MEDICAL ATTENTION IS DEEMED NECESSARY FOR MY CHILD. THIS INCLUDES BUT NOT LIMITED TO X-RAYS, TESTS, HOSPITALIZATION [ C"V ] AND ITS RELATED TRANSPORTATION.

SIGNATURE OF PARENT OR GUARDIAN \_\_\_\_\_ DATE \_\_\_\_\_

**HEALTH HISTORY :** [ IF NECESSARY - ATTACH ADDITIONAL INFORMATION ]

ALLERGIES 1. Please list known **ALLERGIES** .. Please describe the 2. **REACTION** . & 3. **MANAGEMENT** of the allergy.

FOOD \_\_\_\_\_  
 MEDICINE \_\_\_\_\_  
 OTHER \_\_\_\_\_

DIETARY RESTRICTIONS \_\_\_\_\_

MEDICAL CONDITIONS AND MANAGEMENT [ **asthma**, heart; diabetes, bleeding /clotting disorders, convulsions etc.]

OPERATIONS [ type , date] \_\_\_\_\_  
 SERIOUS INJURIES [ type , date] \_\_\_\_\_

PARTICIPANT EVER HAVE :

CHICKEN POX Yes\_\_\_ ב"ה /בלע"ה No\_\_\_ HEPATITIS A Yes\_\_\_ ב"ה /בלע"ה No\_\_\_

CURRENT MEDICATIONS [ for what condition , type ,dosage, directions ]

\_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

NAME OF PARTICIPANT \_\_\_\_\_ BIRTHDATE \_\_\_\_\_

**THIS SIDE TO BE FILLED OUT BY PHYSICIAN**

IMMUNIZATION HISTORY [If have printout, can just attach the printout]

VACCINE	DATES [basic & latest]
DPT SERIES	
DT BOOSTER	
HEPATITIS A VACCINE	
HEPATITIS B VACCINE	
HEMOPHILUS B	
MMR [Measles Mumps Rubella]	
TRI-ORAL POLIO	
TUBERCULIN	
MENINGITIS VACCINE	
OTHER	

BLOOD PRESSURE \_\_\_\_\_ HEIGHT \_\_\_\_\_ WEIGHT \_\_\_\_\_

PLEASE LIST ANY MEDICAL HISTORY WHICH MAY BE RELEVANT TO PARTICIPANT'S....

... ACTIVITY OF HIKING, CLIMBING , SPORTS, SWIMMING , ETC.

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... BEING IN ISRAEL FOR THE SUMMER [weather etc.]

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...GENERAL WELFARE ON THE PROGRAM

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PHYSICIAN'S STATEMENT:

BASED ON MY KNOWLEDGE OF THE HEALTH HISTORY, AS WELL AS MY EXAMINATION ON [date] \_\_\_\_\_ OF THE ABOVE NAMED INDIVIDUAL, HE MAY HAVE THE PRIVILEGE TO PARTICIPATE IN AN ACTIVE SUMMER PROGRAM IN ISRAEL.

STAMP & SIGNATURE OF LICENSED PHYSICIAN \_\_\_\_\_

PRINTED NAME \_\_\_\_\_

LICENSE # \_\_\_\_\_

DATE \_\_\_\_\_

THANK YOU FOR YOUR TIME , PATIENCE , ETC.