



Medical Form – Southern Region



This Medical Form must be filled out by the applicant, parents and a physician who is not related to you and has known you for at least 12 months. In addition, if you are under the care of a specialist, (i.e. cardiologist, neurologist, psychiatrist, psychologist, social worker, physical therapist. etc.) you must submit a written report from a specialist detailing your diagnosis, treatment, and prognosis. Failure to submit such a report can result in your expulsion from this program without any return of funds. To be interviewed both sections of this form must be submitted with the fully completed application packet.

PART 1 - FOR THE APPLICANT (Pages 1-3)

1. If you will be taking prescription medication while on this program you must submit a written report giving full details of each medication. You must travel with a written generic prescription for each medication. You must also bring two complete sets of your medication with you.
2. If any changes take place in your medical or emotional condition within ten (10) days prior to departure of this program, you must immediately submit a full explanatory letter, signed by an appropriate, qualified medical or psychological professional, detailing your diagnosis, prognosis and treatment. Failure to submit such a report may result in your expulsion from this program without any refund.
3. It is our intention to rely on this completed form and supplementary letters in determining your acceptance and continuation in this program. Omissions or misstatements are at your risk and that of your physician(s) or therapist(s).
4. Should you be found to have any mental or physical condition that is not fully disclosed in this Medical Form or in an accompanying letter from an appropriate, qualified medical or psychological professional, then
 - a. you may, at the sole and absolute discretion of the program, be returned to the USA at your own expense, or be treated in the countries you are visiting, at your own expense, and there shall be no refund of monies paid to this program.
 - b. the leadership of this program and its sponsoring organizations are hereby released from all responsibility or liability of any kind whatsoever arising out of any aspect of your medical history and mental or physical condition.

PERSONAL HEALTH HISTORY Gender: Male Female

To be completed by the applicant. Fill in every answer. Do not leave any blank spaces. When not applicable, write N/A. All information is confidential.

Name: _____ **D.O.B.:** _____

Mother Primary PHONE: _____ **Father Primary PHONE:** _____

Home Address: _____
Street City State Zip

Medical Insurance (company): _____ **Policy #:** _____

All Applicants must attach a front and back copy of your insurance card

Family History: (fill in where appropriate)

Father: Living Deceased / Date of Death: _____ Cause of Death: _____

Mother: Living Deceased / Date of Death: _____ Cause of Death: _____

Siblings: Living Deceased / Date of Death: _____ Cause of Death: _____

Check the boxes next to the medical condition listed below that applies to your health history:

- | | | |
|---|---|---|
| <input type="radio"/> Anemia | <input type="radio"/> Kidney Ailments | Visual: |
| <input type="radio"/> Arthritis | <input type="radio"/> Migraines | <input type="radio"/> Eye Glasses |
| <input type="radio"/> Asthma | <input type="radio"/> Measles | <input type="radio"/> Contact Lenses |
| <input type="radio"/> Bleeding Disorder | <input type="radio"/> Mononucleosis | |
| <input type="radio"/> Bronchitis | <input type="radio"/> Motion sickness/Vertigo | Allergies: |
| <input type="radio"/> Chemical Dependency | <input type="radio"/> Mumps | <input type="radio"/> Hay Fever |
| <input type="radio"/> Chicken Pox | <input type="radio"/> Orthopedic Fractures | <input type="radio"/> Insect Stings |
| <input type="radio"/> Convulsions/ Neurological Disorders | <input type="radio"/> Pneumonia | <input type="radio"/> Penicillin |
| <input type="radio"/> Diabetes | <input type="radio"/> Poliomyelitis | <input type="radio"/> Other _____ |
| <input type="radio"/> Eating Disorders | <input type="radio"/> Psychological Problems | _____ |
| <input type="radio"/> Epilepsy | <input type="radio"/> Rheumatic Fever | |
| <input type="radio"/> Eye Ailments | <input type="radio"/> Scarlet Fever | Female only: |
| <input type="radio"/> Fainting | <input type="radio"/> Sinusitis | <input type="radio"/> Regular Menstrual Cycle |
| <input type="radio"/> Frequent Colds | <input type="radio"/> Sleep Walking | <input type="radio"/> Menstrual Problems |
| <input type="radio"/> German Measles | <input type="radio"/> Thyroid Condition | |
| <input type="radio"/> G I/Stomach Problems | <input type="radio"/> Tuberculosis | |
| <input type="radio"/> Heart Ailments | <input type="radio"/> Tumors | |

1) If you checked any of the *above* please *give* all details including name(s), date(s) and address(es) of physicians and hospitals.

Dates of Illness: _____

2) Do you have problems with eating? Yes No If Yes, Please explain:

3) Have you undergone any operations or sustained any injuries? Yes No

If yes, *give* details, including dates, names and addresses of physicians and hospitals below: _____

4) Are you taking any medication now? Yes No If so, please state name of medication, name of physician and condition being treated. _____

5) Condition of your current and general health: _____

Date and nature of last illness: _____

6) Describe any disabilities or restrictions: _____

If none, write "none." _____

7) Are you able to participate in a strenuous program? Yes No

8) *Have you ever* been in any kind of **physical** therapy? Yes No If so, please indicate: _____

Person consulted: _____

Profession: _____ Date(s) of consultation: _____

Reason: _____

9) Have you ever been in any kind of **psychological** or social therapy? Yes No If so, please indicate: _____

Person consulted: _____

Profession: _____ Date(s) of consultation: _____

Reason: _____

Person consulted: _____

Signature of applicant: _____

Signature of parent if applicant is a teen participant: _____

PART 2 - FOR THE PRIMARY CARE PHYSICIAN (Pages 4-6)

NOTES TO THE EXAMINING PHYSICIAN

- 1) **Each March of the Living participant will face a new and strenuous environment, which will be physically as well as emotionally stressful.** They will be living, eating and sleeping in a communal environment. They will be expected to participate in activities which will include long bus rides, walking long distances and other strenuous activities. They will visit places such as Auschwitz, Majdanek and Treblinka, where they will be emotionally affected. Therefore, it is essential that this medical report be as **complete** and **precise** as possible. Please bear in mind that the medical facilities available for participants will cover only acute illness and accidents. There are no facilities available within the framework of the March of the Living for the treatment of chronic disturbances.
- 2) **This form should only be completed by you if you have known the applicant for, at least, the last 12 months.** In addition, if the applicant has been under the care of a specialist (i.e. cardiologist, neurologist, psychiatrist, psychologist, social worker, etc.) **it is essential that the specialist submit a written report for use by the staff of the "March" to better service the applicant.** See contact info in numbers 5 and 7.
- 3) **If the applicant is required to continue receiving medication** while participating in the program, he/she should be given a medical letter providing full details. Since medicine is not often available under the same trade name as in the United States, the full generic name should be given.
- 4) It is our intention to rely on this completed form and supplementary letters in determining the final acceptance of the applicant into this program.
- 5) **If you become aware of any change in the applicant's medical or psychological condition, please notify the Southern Region of the March of The Living. 561-852-6045 or mol@bocafed.org.**
- 6) **The information on this report form and all supplementary material on the physical, mental or psychological condition of the applicant shall be held strictly confidential.**
- 7) **If you have any concern about the participation of the patient in this program, please contact the Southern Region of the March of The Living. 561-852-6045 or mol@bocafed.org.**

PHYSICAL EXAMINATION
(To Be Completed by a Licensed Physician)

	<u>Normal</u>	<u>Abnormal</u>	<u>Describe Abnormality</u>
HEIGHT	_____	_____	_____
WEIGHT	_____	_____	_____
BLOOD PRESSURE	_____	_____	_____
ALLERGIES	_____	_____	_____
DRUG ALLERGIES	_____	_____	_____
General Build	_____	_____	_____
Head	_____	_____	_____
Ears	_____	_____	_____
Eyes	_____	_____	_____
Nose	_____	_____	_____
Throat	_____	_____	_____
Neck	_____	_____	_____
Chest. Lungs	_____	_____	_____
Heart	_____	_____	_____
Abdomen	_____	_____	_____
Hernia	_____	_____	_____
G.I. System	_____	_____	_____
Extremities	_____	_____	_____
Spine	_____	_____	_____
Skin, Lymphatic's	_____	_____	_____
Tanner Development	_____	_____	_____
Nervous System	_____	_____	_____
Mental/Psychological State	_____	_____	_____

