This trip is a gift from Taglit-Birthright Irael

Taglit – Birthright Israel: Canada Israel Experience

SPRING/SUMMER 2010

DOCTOR'S MEDICAL FORM

PARTICIPANT INSTRUCTIONS: Please review the information contained on Page 1 with your doctor. If this form does not contain your first and last name as well as your signature, Canada Israel Experience reserves the right to dispose of this form and you will be responsible for providing a new form.

NOTES TO THE EXAMINING PHYSICIAN:

The new and strenuous environment each participant will face on a Taglit-Birthright Israel: Canada Israel Experience trip takes his/her physical and mental capabilities to the fullest. It is therefore imperative, as a safeguard to the health of the participant, that this report be as complete and precise as possible. It is **recommended** that this form be completed by a physician who has known the applicant for at least 12 months.

In addition, any applicant who has been under the care of a specialist (for example, cardiologist, neurologist, psychiatrist, psychologist, social worker, etc.) **must** submit a written detailed report from a specialist giving **complete diagnosis, prognosis and evaluation**. It is imperative that CIE receives a written report from a specialist to decide the eligibility of the participant.

If a participant is required to continue receiving any prescription medication while under the auspices of the program, he/she should have an **additional** medical letter from the prescribing physician approving the applicant's ability to participate in the program in light of the factors described below.

If any changes take place in the participant's condition within the last ten days before departure, the participant must submit, before departure, an explanatory medical letter, detailing diagnosis, prognosis and treatment. Failure to submit such a letter shall result in expulsion of the applicant from his/her program without any refund.

PLEASE EVALUATE THE APPLICANT'S MEDICAL CONDITION IN LIGHT OF THE FOLLOWING FACTORS THAT DESCRIBE THE PROGRAM:

Social Environment: Most participants will be living in a communal environment. They will be sleeping in a dormitory or sharing living quarters with many other people and eating in communal dining facilities.

Activity: The participants will be expected to participate in extensive tours of the country, which will include walking long distances, climbing, hiking, swimming and other strenuous activities.

Medical Facilities: The physician should also bear in mind that medical facilities available for participants will cover only acute illnesses and accidents. There are no facilities available for the treatment of chronic disturbances. Medical care will very often be entrusted to fully trained para-medical personnel, although a doctor will always be available and on call, as will the local hospitals. In some cases, the patient will be transferred to Jerusalem for specialized medical treatment when necessary, and, where indicated, will later be returned to the country of origin for further treatment.
Canada Israel Experience (CIE) intends to rely on this completed form and supplementary letters in making determination of acceptance for or continuation of the applicant in the program. Omissions or mis-statements are at the risk of the applicant and his/her physician, surgeon, psychiatrist, psychologist or social worker. A medical doctor retained by the CIE may be in contact with the participant's physician should there be any questions or concerns.

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 the CIE as strictly confidential.

Should any participant upon arrival in Israel, or during his/her stay, be found to be suffering from any condition, mental or physical, that is not fully disclosed in this medical form or in an accompanying letter from a qualified medical or psychological professional, then:

- He/she may, at the sole and absolute discretion of the CIE or its representatives in Israel or in Canada, be returned to his/her place of origin at the participant's own expense (and there shall be no refund on monies paid for the program.)
- CIE and its representatives in Canada and in Israel are thereby released from responsibility or liability of any kind whatsoever arising out of any aspect of such participant's medical history and mental or physical condition.

ALL SECTIONS MUST BE COMPLETED IN FULL AND WILL BE TREATED CONFIDENTIALLY.

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NAME OF PARTICIPANT (please print):___________________________________ **DATE:** _________________

DATE OF BIRTH: ___________________________ **TELEPHONE:** ___________________________

PHYSICAL EXAMINATION:

Weight ___________ Height _____________ Respiration _____________ Hearing ________________

Blood Pressure ______________ Vision ___________________________ Pulse __________________

Any Abnormal Findings: ____

PSYCHOLOGICAL EXAMINATION:

1. a) Is the participant currently involved in or has ever been advised to seek psychological therapy of any kind?

   Please Circle: **YES / NO**

   If yes, with whom?

   _____ Psychiatrist _____ Psychologist _____ Psychotherapist ______ Counselor _____Social Worker

   b) If yes, please indicate dates of start and end of treatment:

2. If yes has been answered to any of the above questions, please explain the nature of therapy:

3. **CIE requires information pertaining to ALL current medical conditions and prescribed medication that the applicant has been diagnosed and prescribed for said condition.** Since medicine is often 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. Please **PRINT** list below:

MEDICATION	PHARMACOLOGICAL NAME	FOR TREATMENT OF

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NAME OF PARTICIPANT (please print): ____________________________________ **DATE:** __________________

DATE OF BIRTH: ____________________________ **TELEPHONE:** ____________________________

ALLERGIES:

IF PARTICIPANT HAS SPECIFIC FOOD ALLERGIES, PLEASE NOTE THEM IN THE SPACE PROVIDED ON PAGE 3. PARTICIPANTS ARE RESPONSIBLE FOR CAREFULLY CHOOSING THEIR FOOD ON THE TRIP AND AVOIDING FOODS TO WHICH THEY ARE ALLERGIC.

ALLERGIES (please describe in full, including description of reaction & medication/s required):

___

___

___

Does participant require an epipen? Yes ____ No ____ If Yes, please bring a minimum of three on trip.

VACCINATIONS:

Polio	____	Date: __________________
Tetanus	____	Date: __________________
Measles	____	Date: __________________
Mumps	____	Date: __________________
Rubella	____	Date: __________________
Hepatitis B	____	Date: __________________
Other	____	Date: __________________

MEDICAL CONDITIONS:

Please check off any medical conditions which apply to participant:

____ Arthritis
____ Asthma
____ High/low blood pressure
____ Bronchitis
____ Chicken Pox
____ Convulsions
____ Contact Lenses
____ Diabetes
____ Dizziness
____ Drug use
____ Ear Infections
____ Epilepsy
____ Eyeglasses required
____ Eye Trouble
____ Fainting
____ Frequent Colds
____ Gastrointestinal Problems
____ German Measles
____ Headaches
____ Heart Problems
____ Hepatitis/jaundice
____ Kidney Problems
____ Measles
____ Mononucleosis
____ Mumps
____ Nut Allergies
____ Psychological Counselling
____ Pneumonia
____ Polio Vaccine
____ Rheumatic Fever
____ Scarlet Fever
____ Sexually Transmitted Diseases
____ Sleepwalking
____ Thyroid Disorders
____ Tuberculosis
____ Whooping Cough

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NAME OF PARTICIPANT (please print): ___________________________________ **DATE:** _________________

DATE OF BIRTH: ___________________________ **TELEPHONE:** ___________________________

PHYSICIAN STATEMENT:

I have read the "Notes To Examining Physician" on the cover of the examination form and thereafter have examined ___________________________________ whom I have known for ______ years.

If first time visit, please indicate name of clinic and date here: ___________________________

The results I have recorded represent, to the best of my knowledge, all of the participant'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 participant is physically, mentally and emotionally capable of participating in the program as outlined in "Notes To Examining Physician" on Page 1 of these forms.

I recommend full physical activity: ☐Yes ☐No If no, explain:

I recommend certain restrictions: ☐Yes ☐ No If yes, explain:

I recommend a special diet: ☐Yes ☐ No If yes, explain:

Additional Notes/Comments:

Name of Physician: (**PLEASE PRINT**) ____

Phone: (____)____________________ Address/City: ____

X____ ______________________________

Signature of Physician License Number

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DOCTOR'S MEDICAL FORM

NAME OF PARTICIPANT (please print): ___________________________________ **DATE:** _________________

DATE OF BIRTH: ___________________________ **TELEPHONE:** ___________________________

PARTICIPANT STATEMENT:

I have read the "Notes To Examining Physician" on the Medical Examination Form. I hereby certify that, to the best of my knowledge, this medical form is complete in all of 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 organizers have neither responsibility or liability arising out of such condition. I also realize that medical coverage does not include dental or optometry treatment.

If you have any food allergies, you are responsible for carefully choosing your food on the trip and avoiding foods to which you are allergic. While we will do our utmost to accommodate specific food allergies, please be aware that Israel does not have the same level of allergy awareness as is common in North America and CIE cannot guarantee that your allergy can be completely accommodated. Please call our office to discuss your specific situation with our Registration Manager.

All medication that I take regularly is at my own expense, and this has been detailed on this form or accompanying 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's organizers in Israel. Furthermore, I understand that I am required to complete the online medical information at www.cieregistration.com, as well as purchase **mandatory** additional Travel Medical Insurance.

MUST BE COMPLETED BY PARTICIPANT:

Participant Name: (**please print**) ____

Signature __________________________________Date (mm/dd/yyyy): ____________

PLEASE FAX THIS FORM TO 416-631-6373 OR SCAN AND E-MAIL TO CIEC@UJAFED.ORG AS SOON AS POSSIBLE.