

**Medical Examination Form**  
International School  
University of Haifa

**Part 1: To be completed by applicant**

Student's Name: \_\_\_\_\_ E-mail Address: \_\_\_\_\_

Passport #: \_\_\_\_\_

**Medical History:** Please check all that apply and include dates

\_\_\_\_\_ Heart Disease (including Rheumatic Fever) \_\_\_ / \_\_\_ / \_\_\_\_

\_\_\_\_\_ Gastrointestinal Disease (including ulcer) \_\_\_ / \_\_\_ / \_\_\_\_

\_\_\_\_\_ Liver Disease \_\_\_ / \_\_\_ / \_\_\_\_

\_\_\_\_\_ Kidney Disease \_\_\_ / \_\_\_ / \_\_\_\_

\_\_\_\_\_ Mental Disease (including depression) \_\_\_ / \_\_\_ / \_\_\_\_

\_\_\_\_\_ Neurological Disease (including epilepsy) \_\_\_ / \_\_\_ / \_\_\_\_

\_\_\_\_\_ Lung Disease (including asthma) \_\_\_ / \_\_\_ / \_\_\_\_

\_\_\_\_\_ Diabetes \_\_\_ / \_\_\_ / \_\_\_\_

\_\_\_\_\_ Tuberculosis \_\_\_ / \_\_\_ / \_\_\_\_

\_\_\_\_\_ Anemia \_\_\_ / \_\_\_ / \_\_\_\_

\_\_\_\_\_ Hernia \_\_\_ / \_\_\_ / \_\_\_\_

\_\_\_\_\_ Hypertension \_\_\_ / \_\_\_ / \_\_\_\_

\_\_\_\_\_ Eating Disorder \_\_\_ / \_\_\_ / \_\_\_\_

Other diseases not listed above (including dates): \_\_\_\_\_

Detail major operations and/or hospitalizations (including dates): \_\_\_\_\_

Detail all allergies and drug reactions: \_\_\_\_\_

**Applicant's Statement:**

I hereby certify to the best of my knowledge that the above medical information is correct. I understand that any illness suffered prior to arriving in Israel that has not been described on this medical form may result in my return to my country of origin at my own expense, or result in my treatment in Israel at my own expense. I affirm that I am not addicted to illegal substances (such as narcotics) and I understand that my use of such illegal substances may be grounds for my dismissal from the International School and the University of Haifa.

*\*Note to applicant: If the answer is "yes" to any of the questions on page 3, please provide us with a letter of explanation from your therapist or psychiatrist. This information will be treated confidentially.*

Signature of applicant: \_\_\_\_\_ Date: \_\_\_\_\_

Signature of parent or Guardian (for under 18's): \_\_\_\_\_ Date: \_\_\_\_\_

**Medical Examination Form**  
International School  
University of Haifa

**Part 2: To be completed by a licensed physician who is not related to applicant**

Student's Name: \_\_\_\_\_ E-mail Address: \_\_\_\_\_  
Social Security #: \_\_\_\_\_ Passport #: \_\_\_\_\_

**Notes to the Examining Physician:** Your medical report is necessary for our evaluation of the student's application. Any applicant who has been under the care of a specialist must submit a detailed report giving complete diagnosis, prognosis, and evaluation. If any changes arise in the applicant's condition within 10 days before departure, please submit an explanatory medical letter. This information will be treated confidentially.

**Physical Health**

	Normal	Abnormal	Describe Abnormality
Hearing	_____	_____	_____
Vision	_____	_____	_____
Chest, Lungs	_____	_____	_____
Heart	_____	_____	_____
Vascular System	_____	_____	_____
Abdomen	_____	_____	_____
G.I. System	_____	_____	_____
G.U. system	_____	_____	_____
Upper Extremities	_____	_____	_____
Lower Extremities	_____	_____	_____
Spine	_____	_____	_____
Nervous System	_____	_____	_____
Mental State	_____	_____	_____

Height: \_\_\_\_\_ Weight: \_\_\_\_\_

**Current Medications:**

Generic Name:	Dosage:	Purpose:
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

**Medical Examination Form**  
International School  
University of Haifa

**Mental Health**

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

If so, with whom?    \_\_\_ Psychiatrist            \_\_\_ Psychologist  
                                 \_\_\_ Counselor                \_\_\_ Social Worker

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

\_\_\_\_\_

Has the applicant ever been advised to seek counseling, psychotherapy, or psychiatric care? If yes, please explain circumstances.

\_\_\_\_\_

Has the applicant ever dealt or currently dealing with eating disorders? If Yes, please explain.

\_\_\_\_\_

Additional comments:

\_\_\_\_\_

*\*Note to applicant: If the answer is "yes" to any of the above questions, please provide us with a letter of explanation from your therapist or psychiatrist. This information will be treated confidentially.*

**Physician's Statement**

1. I have read the "Notes to the Examining Physician" on the first page of the Medical Form and thereafter examined \_\_\_\_\_. The results I have recorded represent, to the best of my knowledge, the applicant's medical history and my examination results. I understand that the program organizers in Israel rely on my report. In my opinion, the applicant is physically, mentally, and emotionally capable of studying at the University of Haifa.

\_\_\_ Yes \_\_\_ No

If no, please explain: \_\_\_\_\_

2. I recommend full physical activity.            \_\_\_ Yes            \_\_\_ No

If no, please explain: \_\_\_\_\_

3. I recommend certain restrictions.            \_\_\_ Yes            \_\_\_ No

If yes, please explain: \_\_\_\_\_

4. The applicant can withstand certain changes in diet from which s/he is accustomed.

\_\_\_ Yes \_\_\_ No            If no, please explain: \_\_\_\_\_

Physician's name (please print or type): \_\_\_\_\_

Address: \_\_\_\_\_

Telephone: \_\_\_\_\_ E-mail: \_\_\_\_\_

**Medical Examination Form**  
International School  
University of Haifa

License Number: \_\_\_\_\_ Date: \_\_\_\_\_

**Stamp and signature of physician:** \_\_\_\_\_