University of Haifa
International School

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 Part 3: Mental Health, please provide us with a letter of explanation from your doctor, therapist, psychologist, or psychiatrist. This information will be treated confidentially **(See page 3 for details).**

Signature of applicant: _____ Date: _____

Signature of parent or guardian (if under 18): _____ Date: _____

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:
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

<u>Part 3: Mental Health</u>

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.

_____

Has the applicant ever been diagnosed with any of the following? _____

___ ADD/ADHD ___ Autism
___ Dysgraphia ___ Dyslexia/ Processing Deficits

***If yes, please attach to this document explanation regarding any classroom accommodations/ extended time.**

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 doctor, therapist, psychologist, or psychiatrist explaining the current status of your condition(s) and how it affects you, any medications you are taking, if you will need continued care while abroad, and that there is nothing prohibiting your participation in the program. 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: _____

License Number: _____ Date: _____

Stamp and signature of physician: _____