

AMERICAN ISRAELI MEDI-PLAN, INC.

20533 Biscayne Blvd. Suite N202 Aventura, Fla. 33180 1-800-4-AIM-PLAN E-mail: aim@netvision.net.il

MEDICAL HISTORY FORM



Student Name _____
Last Name
First
Mid

Birthdate: *Month* *Day* *Year*

Passport No: _____ Social Security No. _____

Family Address _____
Address
City
State
Zip

Telephone _____ *Home* _____ *Work* _____ Fax: _____

Present School _____ *Last school attended* Yeshiva _____ *Attending in Israel*

Family Physician _____ Telephone _____

Person to contact in Emergency: _____ Telephone _____

IMMUNIZATION RECORD (CIRCLE No.)

DPT	1	2	3	4	5	DATE OF LAST TETANUS IMMUN.	_____
OPV	1	2	3	4	5	DATE OF LAST POLIO IMMUN.	_____
MEASLES	(DATE)	_____				DATE OF LAST MEASLES IMMUN.	_____
MUMPS	(DATE)	_____				HEPATITUS Vaccine - A	_____ B _____
RUBELLA	(DATE)	_____				OTHER	_____

PAST MEDICAL HISTORY (HAS STUDENT HAD ANY OF THE FOLLOWING? CHECK AND DESCRIBE DEATILS IN SPACE BELOW).

MEASLES _____ RUBELLA _____ MUMPS _____ CHICKEN POX _____ HEPATITIS _____
 INFECTITIOUS MONONUCLEOSIS _____

RECURRENT STREP THROAT _____ RESPIRATORY DISORDERS _____ INTESTINAL DISORDERS _____ URINARY TRACT DISORDERS _____ NEUROLOGICAL DISORDERS _____ PSYCHIATRIC DISORDERS _____ DERMATOLOGICAL DISORDERS _____ GYNECOLOGICAL DISORDERS _____ ALLERGIES (FOOD, MED. ETC.) _____ ACNE _____	EYE PROBLEMS _____ EAR PROBLEMS _____ SINUS PROBLEMS _____ RHEUMATIC FEVER _____ HEART DISEASE _____ BLOOD DISORDERS _____ SKELETAL DISORDERS _____ KIDNEY DISEASE _____ ASTHMA _____ OTHER (explain below) _____
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DESCRIBE DETAILS: _____

LIST BELOW ANY HOSPITALIZATION AND/OR SURGERY THE STUDENT HAS HAD.

<u>AGE OR DATE</u>	<u>PROBLEM OR OPERATION</u>
_____	_____
_____	_____
_____	_____

PHYSICAL EXAMINATION (DESCRIBE DETAILS IN SPACE BELOW)

HEIGHT _____ WEIGHT _____ PULSE _____ BLOOD PRESSURE _____
 VISUAL ACUITY R _____ L _____

	NORMAL	ABNORMAL		NORMAL	ABNORMAL
SKIN	_____	_____	ABDOMEN	_____	_____
EARS	_____	_____	LIVER/SPLEEN	_____	_____
HEARING	_____	_____	HERNIA	_____	_____
TEETH	_____	_____	EXTREMITIES	_____	_____
TONSILS	_____	_____	BACK	_____	_____
GLANDS	_____	_____	GENITALIA	_____	_____
HEART	_____	_____	MENSES	_____	_____
LUNG	_____	_____	OTHER	_____	_____

MEDICATIONS (INCLUDE DOSAGE) _____

HAS THE APPLICANT EVER BEEN DIAGNOSED OR COUNSELLED OR TREATED FOR A LEARNING OR READING DISABILITY? GIVE DETAILS: _____

HAS THE APPLICANT RECEIVED PSYCHOLOGICAL/PSYCHIATRIC COUNSELING? IF YES, HAVE THERAPISTS FORWARD PERTINENT DETAILS. _____

DO YOU HAVE ANY RECOMMENDATIONS OR PRECAUTIONS WITH RESPECT TO DIET, SWIMMING, DIVING, HIKING OR STRENUOUS ACTIVITIES? _____

PHYSICIANS STATEMENT:

I HAVE EXAMINED _____ AND DO/DO NOT CONSIDER HIM/HER PHYSICALLY AND/OR EMOTIONALLY QUALIFIED TO PARTICIPATE IN AN OVERSEAS STUDY PROGRAM IN ISRAEL. I CERTIFY THAT THE ABOVE STATEMENTS ARE TRUE AND COMPLETE TO THE BEST OF MY KNOWLEDGE.

Physicians Signature _____ Phone No. _____ Date _____

PARENTAL DECLARATION AND CONSENT FOR EMERGENCY MEDICAL TREATMENT

I HAVE REVIEWED THIS FORM AND DECLARE THAT TO THE BEST OF MY KNOWLEDGE THE INFORMATION GIVEN IN IT IS TRUE AND ACCURATE.

I DO HEREBY GIVE AUTHORITY TO THE ROSH YESHIVA OR THE ADMINISTRATOR TO OBTAIN NECESSARY EMERGENCY MEDICAL TREATMENT FOR MY SON/DAUGHTER WITH THE UNDERSTANDING THAT THE FAMILY WILL BE NOTIFIED AS SOON AS POSSIBLE.

Signature of Parent or Guardian (Please state) _____ Phone No. _____ Date _____