



MEDICAL FORM

NOTES TO THE EXAMINING PHYSICIAN: Your medical report is necessary for our evaluation of the student's application request. Any applicant who has been under the care of a specialist must submit a written detailed report giving complete diagnosis, prognosis, and evaluation. If any changes arise in the applicant's condition within the last 10 days before departure, the applicant must submit a full explanatory medical letter. This information will be treated confidentially. Please return the completed form to: Ben-Gurion University of the Negev, Office of Student Services, 1430 Broadway, 8th Floor, New York, NY 10018.

APPLICANT'S INFORMATION

Name _____ Birth Date: _____ M F

Home Address _____

Phone _____ Email Address _____

Program: Year Fall Spring Summer

IMPORTANT: If parents are not available in case of emergency, please notify:

Name _____ Relationship to Participant _____

Home Phone _____ Work Phone _____ E-mail Address _____

HEALTH HISTORY: Please answer "Yes" or "No" to the following:

	Y	N		Y	N		Y	N		Y	N
Allergies	<input type="radio"/>	<input type="radio"/>	Diabetes	<input type="radio"/>	<input type="radio"/>	Frequent Colds	<input type="radio"/>	<input type="radio"/>	Pneumonia	<input type="radio"/>	<input type="radio"/>
Hay Fever	<input type="radio"/>	<input type="radio"/>	Dizziness	<input type="radio"/>	<input type="radio"/>	German Measles	<input type="radio"/>	<input type="radio"/>	Poliomyelitis	<input type="radio"/>	<input type="radio"/>
Sting	<input type="radio"/>	<input type="radio"/>	Drug Use	<input type="radio"/>	<input type="radio"/>	Headaches	<input type="radio"/>	<input type="radio"/>	Rheumatic Fever	<input type="radio"/>	<input type="radio"/>
Penicillin	<input type="radio"/>	<input type="radio"/>	Ear Infections	<input type="radio"/>	<input type="radio"/>	Heart Trouble	<input type="radio"/>	<input type="radio"/>	Scarlet Fever	<input type="radio"/>	<input type="radio"/>
Asthma	<input type="radio"/>	<input type="radio"/>	Eating Disorders	<input type="radio"/>	<input type="radio"/>	Kidney Trouble	<input type="radio"/>	<input type="radio"/>	Sleep Walking	<input type="radio"/>	<input type="radio"/>
Bronchitis	<input type="radio"/>	<input type="radio"/>	Epilepsy	<input type="radio"/>	<input type="radio"/>	Measles	<input type="radio"/>	<input type="radio"/>	Thyroid Disorders	<input type="radio"/>	<input type="radio"/>
Chicken Pox	<input type="radio"/>	<input type="radio"/>	Eye Trouble	<input type="radio"/>	<input type="radio"/>	Mononucleosis	<input type="radio"/>	<input type="radio"/>	Tuberculosis	<input type="radio"/>	<input type="radio"/>
Convulsions	<input type="radio"/>	<input type="radio"/>	Fainting	<input type="radio"/>	<input type="radio"/>	Mumps	<input type="radio"/>	<input type="radio"/>	Venereal Disease	<input type="radio"/>	<input type="radio"/>
Other	<input type="radio"/>	<input type="radio"/>	Other	<input type="radio"/>	<input type="radio"/>	Other	<input type="radio"/>	<input type="radio"/>			

Please give all details concerning any allergy to which "Yes" is answered above, including details of medications required. For those who use Epinet Jr., it is not easily available in Israel and an additional supply should be taken with the applicant).

Has the applicant ever suffered any chronic or recurring illness? If yes, give details.

Has the applicant undergone any operation or sustained serious injuries? If yes, give details.

Is the applicant taking any medication now? If so, please specify name of medication(s) and condition being treated.

PHYSICAL EXAMINATION

	NORMAL	DEVIATION FROM NORMAL		NORMAL	DEVIATION FROM NORMAL		NORMAL	DEVIATION FROM NORMAL
Skin	<input type="radio"/>	<input type="radio"/>	Lungs	<input type="radio"/>	<input type="radio"/>	Blood Pressure	<input type="radio"/>	<input type="radio"/>
Eyes	<input type="radio"/>	<input type="radio"/>	Abdomen	<input type="radio"/>	<input type="radio"/>	Hemoglobin	<input type="radio"/>	<input type="radio"/>
Ears	<input type="radio"/>	<input type="radio"/>	Tonsils	<input type="radio"/>	<input type="radio"/>	Urinalysis	<input type="radio"/>	<input type="radio"/>
Hearing	<input type="radio"/>	<input type="radio"/>	Feet	<input type="radio"/>	<input type="radio"/>	Albumin & Sugar	<input type="radio"/>	<input type="radio"/>
Nose	<input type="radio"/>	<input type="radio"/>	Spine	<input type="radio"/>	<input type="radio"/>	Microscopic	<input type="radio"/>	<input type="radio"/>
Teeth	<input type="radio"/>	<input type="radio"/>	Appendix	<input type="radio"/>	<input type="radio"/>			
Heart	<input type="radio"/>	<input type="radio"/>	Hernia	<input type="radio"/>	<input type="radio"/>			

Weight _____ Height _____ Blood Type _____ Blood Pressure _____ Pulse _____

PSYCHOLOGICAL

Is the individual currently involved in psychological therapy of any kind? Yes No
 If so: with whom? Psychiatrist Psychologist Counselor Social Worker
 Is the individual receiving any medication? Yes No If so, please specify: _____
 Is there any history of psychological or psychiatric care? Yes No If yes, give dates: _____
 Has the applicant ever been advised to have counseling, psychotherapy, or psychiatric care? Yes No
 Additional comments: _____

Please note that the BGU campus is not fully accessible to all disabled student.

PHYSICIAN'S STATEMENT

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, all the applicant's medical history and my findings on examination. I understand that the program organizers in Israel will rely on my report. In my opinion the applicant is physically, mentally, and emotionally capable of participating in the Overseas Student Program at Ben-Gurion University of the Negev.

Yes No If no, please explain: _____

I recommend full physical activity. Yes No If no, please explain: _____

I recommend certain restrictions. Yes No If no, please explain: _____

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

Yes No If no, please explain: _____

Physician's Name _____ Physician's signature _____

Address _____

Phone _____ License Number _____

APPLICANT'S STATEMENT

I have read the "Notes to the Examining Physician" on the first page of the Medical Form. I hereby certify that, to the best of my knowledge, this medical form is complete in all 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 has neither responsibility nor liability arising out of such condition. I also realize that medical coverage does not include dental treatment or any form whatsoever, or eyeglasses.

Name of Participant _____ Applicant's Signature _____

Date _____ Parent's Signature (if applicant under 21) _____