Registration/Health Form – Temple Israel Center Teens

February 14-24, 2019

Name & Passport Information of Participant (please write legibly)			
Last Name (as appears exactly on passport)	Given Name (as appears exactly on passport)	Nickname	
Passport Number	Nationality	Exp. Date (DD/MM/YY)	
Date of Birth (DD/MM/YY)	Do you have Israeli citizenship? ☐ Yes ☐ No	Gender M F	T-Shirt Size XS S M L XL XXL

Parent/Guardian #1 Contact Information			
Name	Address		
Tel. Home	Tel. Work	Cell	Relationship to Participant

Parent/Guardian #2 Contact Information			
Name	Address		
Tel. Home	Tel. Work	Cell	Relationship to Participant

Emergency Contact Information		
Name	Cell	Relationship to Participant
Do you have any family or friends in Israel? Yes No	If Yes, please list name, cell phone, email, and relationship to participant:	

Dietary Restrictions/Food Sensitivity (please note that all meals will be Kosher)

☐Vegetarian ☐Vegan ☐ Pescatarian ☐ Lactose Intolerant ☐ Gluten Free/Celiac ☐Other _____________

Health Conditions/Disorders - Participant has been diagnosed with:

☐Diabetes ☐Asthma ☐ Celiac Disease ☐ ADD/ADHD ☐Depression ☐Panic/Anxiety Disorder

☐Other (Please explain)

Medications (Prescription and OTC)				
#1	RX Name	Generic (if known)	Dosage	Reason
#2	RX Name	Generic (if known)	Dosage	Reason
#3	RX Name	Generic (if known)	Dosage	Reason
#4	RX Name	Generic (if known)	Dosage	Reason
#5	RX Name	Generic (if known)	Dosage	Reason

Allergies to Medications (List Below)	Additional Allergies other than food/medications (List Below)

Hospitalizations: Has the participant ever been hospitalized for any physical and/or psychiatric reason? Yes No.
If Yes, please list below:

Date:	Reason:	Comments
Date:	Reason:	Comments

Primary Care Physician Contact Info:	
Name	Tel:
Psychologist/Psychiatrist Contact Info: (If applicable)	
Name	Tel:
Does the participant have any physical limitations? No Yes. If Yes, please explain below	
Have there been any deaths or illness in your family? No Yes. If Yes, please explain below	
Has there been any change in the family situation in the past year? No Yes. If Yes, please explain below	
Is there any other information we should know about the participant? No Yes. If Yes, please explain below	

PLEASE NOTE: It is Keshet policy for a staff member to accompany participants in the examination room while being examined by a doctor or other health professional unless asked by the patient to leave.

DISCLOSURE: By my signature I affirm that this health history is correct and accurately reflects the health status of the participant to whom it pertains. I understand that the program includes physical activity, which may include hiking, biking, and swimming in a dry, hot climate, especially during the summer months. Omissions or misstatements are at the risk of the participant, parent(s)/guardian(s), and physician(s). 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 form or in an attached letter from a physician or specialist, then: 1) S/he, at the sole discretion of Keshet, may be returned to his/her place of origin at the participant’s own expense, or be treated in Israel at the participant’s own expense, and there shall be no refund of monies paid for the program; and 2) Keshet and its representatives are thereby released of all responsibility or liability of any kind whatsoever arising out of any aspect of such participant’s medical history and mental or physical condition.

PERMISSION TO TREAT: The participant has permission to participate in all program activities except as noted by me and/or an examining physician. I give permission to the physician selected by Keshet to order x-rays, routine tests, and treatment related to the health of the participant for both routine health care and emergency situations. If I cannot be reached in an emergency, I give my permission to the physician to hospitalize, secure proper treatment for, and order injection, anesthesia, or surgery for the participant. I understand that the information on this form will be shared on a “need to know” basis with program staff. I give permission to photocopy this form. In addition, Keshet has permission to obtain a copy of the participant's health record from providers who treat him/her, and those providers may talk with the program’s staff about the participant’s health status.

By my signature I affirm that this health history is correct and complete to the best of my knowledge and that I have read, understood and agree to the Terms and Conditions specified in this form.

Parent/Guardian’s Name:________________________Signature:_______________________Date:______________________

Physician's Report

Participant's Name: ____

Measurements: Height:________________ Weight:________________ Blood Type: ____________ Rh:_________

Immunization History:
Has the participant been protected against the following diseases? Please note year of most recent immunization.

Immunization	Yes	No	Date		Immunization	Yes	No	Date
Diphtheria					Polio (Salk)			
German Measles					Polio (Oral Sabin)			
Measles					Smallpox			
Mumps					Tetanus			
Hepatitis A					Whooping Cough			
Hepatitis B					Other:			
These immunizations are not required by Israel. Immunizations should be based on consultation with physician.								

Health Examination:
The participant is under the care of a physician and/or therapist for the following conditions:
____
____
____

Current treatment (include current medications): ____
____
____

Explanation of any reported loss of consciousness, convulsions or concussion: ______________________________
____
____

Note to examining physician: The participant will be participating in an Israel Program. The main activities may include touring, hiking, biking, swimming, and physical exertion in the sun. The Israeli climate is dry and hot, especially during the summer months.

Recommendations and Restrictions while in Israel:
____
____

Physician's Health Statement:
I have known the participant for ___ years and have examined the above person within the last year. To the best of my knowledge the information included in this form is complete and correct. In my opinion, the above participant is **capable / incapable** (please circle one) of participating in this Israel program. I understand that Keshet and its representatives in Israel will rely on my above report and finding.

Licensed Physician's Name: ____

Date of Examination: ______________________________________

Phone Number: ______________________________________

Licensed Physician's Signature: ______________________________________