



Ohr Torah Stone - Nelech

HaTe'ena St 1, Efrat, Israel 90435 | ots.org.il/nelech

Name of Applicant _____

Medical Form

Part I: Medical Authorizations

Last Name _____ First (legal) Name _____ Sex ___ M ___ F Birth date ___/___/___
Address _____ City _____ State _____ Zip _____
Home Phone _____ Parent/Guardian Cell Phone _____ Relationship _____

A. Parent/Guardian Authorization for Health Care:

I certify that all information in this medical form is true and accurate and there has been no willful omission of data. My child has permission to engage in all aspects of OTS-Nelech activities except as noted by me and/or an examining physician. I give permission to the healthcare professionals selected by OTS-Nelech to order x-rays, routine tests, and treatment related to the health of my child for both routine health care and in emergency situations. If I cannot be reached in an emergency, I give my permission to the healthcare professionals to hospitalize, secure proper treatment for, and order injection, anesthesia, or surgery for this child. I understand 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, the program has permission to obtain a copy of my child's health record from providers who treat my child and these providers may talk with the program's staff about my child's health status.

Signature of Custodial Parent/Guardian _____ Relationship to applicant _____ Date: _____

B. To The Examining Physician:

Nelech is a highly structured semester-long (~4.5 month) high school program demanding physical and emotional stamina. Participants live within a group framework, and must be capable of thriving within a stressful and intensive environment. The days are full and intense, and all participants are required to fully participate in all activities. Please see ots.org.il/nelech for a full description of our program and for further contact information if there are any questions.

I have examined the above applicant and certified the medical information contained in this document. It is my opinion that the applicant is physically and emotionally fit to participate in Ohr Torah Stone's Nelech program.

Licensed Physician's Signature

Date of Examination

Address

Phone Number

Email address

Date of Form Completion

By (Initial if completed by nurse or physician's assistant)

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Part II: To be completed in detail by a physician who has examined the applicant.

A. Allergies and Diet ___ No Known Allergies ___ No Dietary Restrictions

Allergies To	List	Describe Previous Reactions
___ Foods		
___ Medications		
___ Environment		
___ Other Allergies		
___ Any Dietary Restrictions		

B. Physical Examination (Must be completed within a year of the start of the program):

All applicants with ongoing medical issues must be examined within six-months of the start of the program.

DATE _____ Physical exam done today: ___ Yes ___ No (If "No," date of last physical: _____) DD/MD/YYYY

Height _____ Weight _____ Blood Pressure _____/_____

Abnormal physical findings: _____

C. Health History- To Be Completed by Physician :

Check all relevant conditions:

- Anemia
- Arthritis
- Asthma*
- Bed wetting
- Bleeding problem*
- Bronchitis
- Cancer
- Chest pain*
- Constipation
- Diabetes*
- Eczema
- Eye problems
- Fainting, dizziness*

- Fatigue
- Fracture
- Frequent diarrhea
- Frequent headaches or migraines
- Hearing loss
- Heart murmur
- Hepatitis*
- HIV infection*
- Hyperactivity
- Hypoglycemia
- Irritable bowel disease*
- Irregular heart rate*
- Lyme disease

- Menstrual disorder
- Mononucleosis
- Persistent cough
- Pneumonia*
- Recurrent ear infection
- Seizures*
- Severe stomach aches*
- Sinus infection
- Sprains
- Swimmer's ear
- Thyroid Disease
- Urine infection
- Wheezing
- Other:

Mental Health Conditions:

- Anxiety*
- ADD / ADHD*
- Bipolar Disorder*
- Depression*
- Eating disorder or disordered eating*
- Obsessive Compulsive Disorder*
- Panic Attacks*
- Sleeping difficulties (i.e., insomnia)*
- Sleep Walking*



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Answers corresponding to Section 1: Physical Conditions

*** Starred items: A detailed letter must be provided from a licensed health-care professional describing the situation and treatment.**

1. Elaborate on the above conditions and describe any disability or chronic illness for which the applicant is under the care of a physician and/or therapist:

2. Describe any operations or serious injuries (including dates)*:

3. Describe any ongoing medical treatment, including treatment to be continued in Israel:

Answers corresponding to Section 2: Mental Health Conditions * Starred items: A detailed letter must be provided from a licensed mental health professional describing the situation and treatment.

1. Has the applicant been under psychiatric or psychological care within the last two years? Yes * No Briefly describe here. Please include the start and end dates of treatment, initial reason for referral, frequency of treatment (i.e., weekly) and any hospitalizations (inpatient or outpatient treatment).

2. Please provide a detailed letter separately from the licensed mental health professional (i.e., therapist-psychiatrist, psychologist and/or social worker). The letter should include: relevant information about the student's treatment and explicit permission for the person to participate on the program, as well as the therapist's suggestions of how we can help the teen cope while on the program. The therapist should also note if s/he gives permission for the student to be in touch with them when necessary while on the program.

3. If answered yes for #45 – "Eating disorder or disordered eating", please note if there has been any significant weight change and over what time period, include current BMI (from a doctor), and specify if diagnosed with a specific eating disorder (i.e., anorexia, bulimia, binge eating).

4. Please list any significant life events that continue to affect the applicant's life (i.e., death in the family, current illness of a caretaker /parent /sibling, separation or divorce, recent move to a different city, etc.). Please explain.

5. Please list any trauma or significant information not included in the above categories.



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D: Physician Recommendations/ Restrictions while in Israel:

Medication: ___ This applicant will not take any daily medications while attending OTS - Nelech.

___ This applicant will take the following daily medication(s) while attending OTS - Nelech.

“Medication” is any substance a person takes to maintain and/or improve their health. This includes vitamins & natural remedies. **Parents must provide enough medication to last the entire period the participant will be in Israel. All medications must be blister packed before arrival in Israel. All medications must be handed over to the OTS - Nelech staff upon arrival in Israel.**

Name of Medication	Date Started	Reason for Taking It	When is it given?	Amount/Dose Given	How is it given?

Please list any medical restrictions:

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E. Immunization History:

OTS - Nelech requires that all participants be vaccinated for Hepatitis A, Meningococcal Meningitis (MCV4), and Measles, Mumps, Rubella (MMR). Hepatitis B vaccinations are strongly recommended. Should a participant not have all of the required vaccinations without a valid medical exemption, they will not be permitted to participate in the program. If you have any questions, please contact Nelech staff.

Has the participant been protected against the following (check and note year of most recent immunization)? Underlined Immunizations must be current. Copies of immunization forms from health-care providers or state or local government are acceptable:

Required Immunizations	Dates		Immunizations	Yes	No	Dates
<u>Diphtheria, tetanus, pertussis DPT / DT / DTap</u>	Completed:		Hepatitis B			
<u>Tetanus booster (Td or Tdap) (Required at 12 years of age)</u>			Pneumococcal (PCV)			
<u>Mumps, measles, rubella (MMR) (two doses required)</u>	#1	#2	Haemophilus Influenzae type B			
<u>Polio (IPV)</u>	Completed:		Varicella (chicken pox) Has the participant had chicken pox?			
<u>Hepatitis A</u>	#1	#2	If never had chicken pox, two doses of varicella vaccine.			#1 #2
<u>Meningococcal Meningitis (MCV4) (Required at 12 years of age, booster dose at 16)</u>	#1	#2	Other:			
Tuberculosis (TB)		___ Neg ___ Pos				

Part III: To be completed by parent/guardian:

A. Personal Health Coverage

(Please provide a copy of the insurance card with this form. This information is required to cover pre-existing conditions or treatments not included in the Israel-based group policy that OTS - Nelech that will be coordinating):

Name of Primary Physician: _____ Phone: _____

Name of Specialist/Therapist: _____ Phone: _____

Health Insurance Company: _____ Policy Number: _____