Taglit-Birthright Israel Amazing Israel
MEDICAL FORM

Instructions:

- This form may **NOT** be completed by a family member.
- Applicants are **REQUIRED** to fill out page 6 and sign page 7 prior to submitting this form.
- Pages 1-3 are to be completed by a general physician with access to the applicants medical history.
- Any applicant who has been under the care of a mental health professional in the past 5 years must have their treating professional fill out page 4 and provide their signature and stamp at the bottom.
- If the applicant has taken any prescription medication in the past 5 years, they MUST have their prescribing physician fill out page 5 of this form and provide their signature and stamp at the bottom.
- If pages 4 and 5 are not relevant to the applicant the general physician must note they are not applicable, sign and stamp both pages.
- It is imperative that Amazing Israel receives this completed form to decide the eligibility of the applicant and cater best for their specific needs. Based on the information provided in this form Amazing Israel may request an additional clearance letter from the applicant's treating professional.

NOTE TO THE EXAMINING PHYSICIAN

Amazing Israel intends to rely on this completed form and supplementary letters in determining acceptance or continuation of the applicant in the program.
Omissions or incorrect information are at the risk of the applicant and their treating health care professional. A medical doctor retained by Amazing Israel may be in contact with the applicant's physician should there be any questions or concerns.

ALL SECTIONS MUST BE COMPLETED IN FULL
ALL INFORMATION GIVEN IS STRICTLY CONFIDENTIAL

APPLICANTS FULL NAME:_____

APPLICANTS DATE OF BIRTH:_____

DATE OF EXAMINATION:_____

APPLICANTS HEIGHT:_____

APPLICANTS WEIGHT:_____

All Participants will be expected to **FULLY** participate in extensive tours of the country, which will include walking long distances, climbing and hiking including uphill as well as other strenuous activities. For those that are on an Extreme trip there will be MUCH more physical activity.
There is NO option to sit out, stay behind or opt out of an activity. All activities are **MANDATORY**.

Is the applicant physically able to fully participate: **oYes oNo** If no, explain:_____

The applicant can attend with no restrictions: **oYes o No** If no, explain:_____

I recommend a special diet: **oYes o No** If yes, explain:_____

1. Has the applicant ever undergone any surgical procedures? If yes, please elaborate:

   _____

2. Is the applicant currently undergoing or has the applicant been advised to seek psychiatric therapy of any kind in the past 5 years? If yes, applicant is required to have their treating professional **fill out page 4**. If no, please indicate this on pages 4 and 5 as well as below.

   Please Circle: **YES / NO**

3. Has the applicant ever been diagnosed with any condition, medical or otherwise?

   _____

   _____

4. Has the applicant ever been diagnosed with any of the following:

   o ADD/ADHD o Seizure disorder o Social Anxiety o Anxiety o OCD

   o Depression o Asperger Syndrome o PDD/ASD /HFA o PTSD o Bi-Polar Disorder

   o Schizophrenia o Mood Disorder o Panic disorder o Other_____

➢ If indicated yes, please have the applicants treating professional fill out pages 4 and 5.

5. Has the applicant been treated or have any history of any addictions or substance abuse? If yes, please give details:

   Substance type:_____

   Type and dates of treatment:_____

   Period of sobriety:_____

6. Does the applicant have any allergies:

   Allergen:_____Reaction:_____Treatment:_____

   Allergen:_____Reaction:_____Treatment:_____

   Allergen:_____Reaction:_____Treatment:_____

7. Does the applicant have difficulty with any the following:

   Walking for several hours at a time Please Circle: **YES / NO**_____

   Hiking for several hours at a time Please Circle: **YES / NO**_____

   Late nights / Early Starts Please Circle: **YES / NO**_____

   Social interaction Please Circle: **YES / NO**_____

Medical Facilities: The physician should also bear in mind that medical facilities available for participants will cover only acute illnesses and accidents. There are no facilities available for the treatment of chronic disturbances. Medical care will very often be entrusted to fully trained para-medical personnel, although a doctor will always be available and on call, as will the local hospitals. In some cases, the patient will be transferred to Jerusalem for specialized medical treatment when necessary, and, where indicated, will later be returned to the country of origin for further treatment.

Should any participant upon arrival in Israel, or during his/her stay, be found to be suffering from any condition, psychiatric or physical, that is not fully disclosed in this medical form or in an accompanying letter from a qualified medical or psychological professional, then:

- They may, at the sole and absolute discretion of Amazing Israel and its representatives in Israel or in the US, be returned to their place of origin at the participant's own expense (and there shall be no refund on deposits paid for the program.)
- Amazing Israel and its representatives in the U.S. and in Israel are thereby released from responsibility or liability of any kind whatsoever arising out of any aspect of such participant's medical history and psychiatric or physical condition.
- If any changes take place in the participant's condition before departure, the participant must submit, before departure, an explanatory medical letter, detailing diagnosis and treatment.

Please feel free to write additional comments below:

PHYSICIAN STATEMENT:

I have read the "Notes To Examining Physician" on the cover of the examination form and thereafter have examined_____whom I have known for_____years.

If first time visit, please indicate name of clinic and date here:
_____

The results I have recorded represent, to the best of my knowledge, all of the applicant's medical history and my findings on examination. I understand that the program organizers in Israel will rely on my report and findings. In my opinion the applicant is physically, psychiatrically and emotionally capable of participating in the program.

Name of Physician: (Please Print) _____

Physician's Signature X _____

Phone: ( ) _____

Address: _____

License Number
Physician/Surgery Stamp:

Mental Health Professional's form

If the applicant has been under the care of a mental health professional (for example, therapist, psychologist, psychiatrist etc.) in the past 5 years the applicant MUST have their treating professional fill out this page and provide their signature and stamp at the bottom.
If the applicant has NOT been under the care of a mental health professional (for example, therapist, psychologist, psychiatrist etc.) in the past 5 years the general physician completing this form will indicate not applicable below and sign the page.

Start date of treatment _____

End date of treatment_____

Has the applicant been diagnosed with any of the following:

o ADD/ADHD o Seizure disorder o Social Anxiety o Anxiety o OCD

o Depression o Asperger Syndrome o PDD/ASD /HFA o PTSD o Bi-Polar Disorder

o Schizophrenia o Mood Disorder o Panic disorder o Other _____

Please detail below if, in your opinion the applicant is physically, psychiatrically and emotionally capable of participating in the program. The program will include extensive tours of the country, which will include walking long distances, climbing and hiking including uphill as well as other strenuous activities. For those that are on an Extreme trip there will be MUCH more physical activity. They will also be expected to share living space with 2 or 3 other participants.

_____

_____

_____

_____

_____

_____

_____

Name of Physician: (Please Print) _____

Physician's Signature X _____

Phone: ( ) _____

Address: _____

License Number
Physician/Surgery Stamp:

MEDICATION FORM:

If an applicant has been prescribed medication in the past 5 years they are required to have their specialist or prescribing physician fill out this page.
This page is to be completed by the applicants prescribing physician.
In the event a specialist was not consulted this page may be filled out by the applicant's general physician.
If the applicant has not taken any prescription medication in the past 5 years the general physician will indicate not applicable and sign below.

Diagnosed Condition:	Date treatment started/ Date of treatment discontinued:	Medication & Dosage Prescribed:	Cleared for full participation and travel:
	/		YES / NO
	/		YES / NO
	/		YES / NO
	/		YES / NO
	/		YES / NO
	/		YES / NO
	/		YES / NO

All Participants will be expected to **FULLY** participate in extensive tours of the country, which will include walking long distances, climbing and hiking including uphill as well as other strenuous activities.
For those that are on an Extreme trip there will be MUCH more physical activity.
There is NO option to sit out, stay behind or opt out of an activity. All activities are **MANDATORY**.

Is the applicant physically able to fully participate: **oYes oNo** If no, explain:_____

The applicant can attend with no restrictions: **oYes o No** If no, explain:_____

Name of Physician: (Please Print) _____

Physician's Signature X _____

Phone: ( ) _____

Address: _____

License Number
Physician/Surgery Stamp:

Please make sure that you fill in the following, accurately, truthfully and clearly. Failure to do so could result in your dismissal from the program. Please use additional pages if necessary.

Applicant Name: (Please Print) _____

International Health Insurance Provider: _____

Policy Number:_____

If you intend to purchase insurance after your final acceptance is issued, please indicate this above. Please send us this information via email as soon as you have it.

(It is a requirement of Taglit-Birthright Israel that you have medical & Travel coverage while you are in Israel. Please call your current insurance provider to see if you are covered in Israel. If your current provider does not cover you please visit our site to purchase insurance. The requirement for travel insurance is if your trip is cancelled or delayed etc. Taglit-Birthright Israel: Amazing Israel is not required to reimburse you for ANY costs)

Do you have any special dietary requirements that we will need to accommodate while you are in Israel?

Vegetarian:	Vegan:
Gluten Free:	Lactose free:
Diabetic:	Other:

Please list any allergies that you have (as well as what you use to treat them):

Allergy:	Treatment / Severity:

*If you carry an Epipen you will need to bring 3 with you to Israel (not expired)

Please list any medications and dosage that you are currently on:

Medication:	Dosage:	Treatment of:

This form is ONLY complete if the applicant statement is signed by the applicant and emergency contact information is filled out

APPLICANT STATEMENT:

I have read the "Notes To Examining Physician" on the Medical Examination 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, physiological 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 organizers have neither responsibility or liability arising out of such condition.

I also realize am required to purchase separate international travel/medical insurance prior to my departure and that proof of this is required.

I understand and agree that if this form is not returned in full prior to Amazing Israel before deadline date I will be removed from the program and will forfeit my deposit.

All medication that I take regularly is at my own expense and has been detailed on this form or additional letters.

I also give my full permission for all treatment of any nature deemed necessary by doctors in Israel to be extended to me within the framework of the Medical Services of the program's organizers in Israel.

Signature_____

Date (mm/dd/yyyy): _____

Should an emergency arise, and we need to contact someone on your behalf who should we call?

Name: _____

Relation_____

Phone Number_____

Please make sure to include any additional doctor's notes when uploading your medical form

This trip is a free gift Birthright Israel.

COVID 19

This MUST be signed by your doctor.

1. Have you ever tested positive for COVID 19? Yes No

2. What was the date of your positive COVID 19 test? _____

3. Have you received a vaccination for COVID 19? Yes No

4. What were the dates of your COVID 19 vaccinations? _____

5. Which Vaccine did you receive? _____

Name of Physician: (Please Print) _____

Physician's Signature X _____

Phone: ( ) _____

Address: _____

License Number
Physician/Surgery Stamp:

*Israel's Ministry of health requires all persons visiting Israel with an organized tour to be fully vaccinated or recovered from COVID 19 and have had at least ONE vaccine.

In order to board the flight to Israel you are required to present a negative PCR test taken within 72 hours of departure, upon arrival in Israel a serological test will be taken to determine antibodies. Anyone found to not have antibodies will be returned to the United States.

These regulations are current as of May 9th 2021. Please contact Amazing Israel for questions about any changes to regulations.