icnext Cohort 6 Israel Mission

June 10 – 21, 2018

Medical – *TO BE COMPLETED BY A PHYSICIAN*

Student's name: _____ Age _____

Height: _____ Weight: _____ Sex: **M** or **F (**please circle)

Immunization History*

Please check and note year of most recent immunizations.

	Yes	No	Date		Yes	No	Date
Diphtheria	____	___	_____	Tetanus	___	____	_____
German measles	____	___	_____	Polio (Salk)	___	____	_____
Measles	____	___	_____	Polio (oral Sabin)	___	____	_____
Mumps	____	___	_____	Other: _____	___	____	_____
Whooping cough	____	___	_____	other: _____	___	____	_____

**These immunizations are not required by U.S. or Israel. Immunizations should be based on consultation with physician.*

Health History

Date of most recent exam: _____

The applicant is under the care of a physician for the following conditions: _____

_____

Current treatments (include current medication): _____

_____

In my opinion, the conditions listed above does ____/ does not ____ preclude his/her participation in an active trip & outdoor activities program.

Explanation of any reported loss of consciousness, convulsion, or concussion: _____

_____

Does the applicant have: Epilepsy? ( ) yes ( ) no Diabetes? ( ) yes ( ) no

Recommendations and Restrictions while in Israel

Any treatments to be continued in Israel: _____

_____

Any medication to be administered in Israel (specific dosages): _____

_____

Any medically prescribed meal plan or dietary restrictions: _____

Any allergies (food, drugs, plants, insects, etc.): _____

Any restriction to full participation (specify): _____

_____

Licensed physician's signature: _____ Phone: _____

Print Physician's name: _____ Date: _____

****Initial & name if completed by a nurse or physician's assistant _____**