icnext 8 Israel Mission
June 7 – 18, 2020

Information to be Completed by a Physician

Student's Name _____

Recommendations and Restrictions for student 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:

_____

_____

Allergies: _____

Any restriction to full participation (specify):

_____

_____

Licensed physician's signature:**

_____

Print Physician's name: _____

Date: _____ Phone: _____

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

_____