

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**

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