A. NOTES TO THE EXAMINING PHYSICIAN & THE CANDIDATE

The applicant is a candidate to participate in one of our Israel based programs. The purpose of this document is to safeguard his/her health, and therefore it is imperative that this report be as complete and precise as possible. This form should be filled out by a physician who has known the applicant for at least 18 months prior to filling out this form. In addition, any applicant who has been under the care of any specialist (for example: cardiologist, neurologist, psychiatrist, psychologist, social worker etc.) must submit a detailed report from that specialist giving a complete diagnosis, prognosis and evaluation. The program organizer may request additional documents or reports for clarification. The medical information on the physical and mental state of the applicant is confidential, but will be shared with subcontractors responsible for the day-to-day running of the program.

If a participant is required to continue receiving medication while under the auspices of the program, this has to be reported in detail, and the participant must bring a sufficient supply of the medicine with him/her.

If any changes take place in the participant's condition **after** the examination but **before** the beginning of the program, the participant must submit, before departure, an explanatory medical letter, detailing diagnosis, prognosis and treatment.

Should a participant, after arrival in Israel, be found suffering from any condition, mental or physical, that is not fully disclosed in this medical form or accompanying letter then he/she may, at the sole discretion of the program organizer, be returned to his or her home country at his/her own expense (with no refund from the program).

The Program Organizer and its representatives in Israel are hereby released from responsibility or liability of any kind whatsoever arising from any aspect of such participants medical history and/or physical and mental condition.

The medical insurance is valid only when the volunteer is staying in the Kibbutz in the volunteer program.

Non-compliance with any of the requirements and conditions stated in this document may influence the decision of acceptance to the program, and/or may result in the expulsion of the participant from the program with no refund.

FOR THE PHYSICIAN'S INFORMATION:

1. ***Climate:*** Participants will be living and working/volunteering in a sub-tropical climate, with temperatures reaching 104 degrees Fahrenheit/40 degrees Celsius. The climate is mostly dry with semi-arid conditions over a large part of the country.
2. ***Participants' Activities:*** These may include strenuous physical work in the sun, food handling, domestic work, and work with livestock. Participants will also engage in a number of tours of the country, which may involve walking long distances and climbing.
3. ***Social Environment:*** Most participants will be living in a communal environment. They will be sleeping in a dormitory or sharing living quarters with others.
4. ***Medical Facilities:*** The physician should bear in mind that medical facilities are available for acute illnesses and accidents only and do not cover routine, chronic or any kind of pre-existing conditions including dental treatment.
5. ***General Conditions:*** The combination of unfamiliar living conditions, different food, lack of privacy, unusual working hours, language and culture can all prove stressful to anyone who is not in robust physical and mental health.

B. PERSONAL HEALTH HISTORY QUESTIONNAIRE (confidential)

Applicant's full name _____ Passport number _____

Date of Birth: [d/m/y] ___/___/_____ Gender **M** **F** Examination date: [d/m/y] ___/___/20___

Blood Type: _____ Date of last Tetanus immunization: [d/m/y] ___/___/20___

MEDICATION that applicant takes chronically:

Drug: _____ against/for?: _____ dose: _____

Drug: _____ against/for?: _____ dose: _____

		NO	YES[1]	DETAILS[2]
1	**Abnormal general build**			
2	**Limitation carrying heavy things**			
3	**Limitation in mobility / physical handicap**			
4	**Limitation in performing daily tasks**			
5	**Orthopedic disturbances / back trouble**			
6	**Obesity / abnormal weight loss/gain**			
7	**Asthma; Chronic lung condition**			
8	**Heart trouble**			
9	**Abnormal blood pressure**			
10	**Ear / Hearing trouble**			
11	**Eyes / Vision trouble**			
12	**Skin conditions**			
13	**Sexually Transmitted Disease**			
14	**Malignant disease, cancer and AIDS**			
15	**Epilepsy**			
16	**Diabetes**			
17	**Dizziness or fainting attacks**			
18	**Nervous system disturbances**			
19	**Allergies/ Dietary restrictions/ Special Food**			
20	**Eating Disorders**			
21	**Penicillin or other drug reactions**			
22	**Chronic or recurring illnesses**			
23	**Mental disorder; Depression**			
24	**Recent psychiatric treatment**			
25	**Learning disabilities (eg. dyslexia)**			
26	**History of drug dependency/abuse**			
27	**History of alcohol abuse**			
28	**Operations (past & planned) / injuries**			
29	**Hospitalizations (past & planned)**			
30	**ANY other sickness/disease/ health disorder**			

[1] **If YES, please indicate details (eg. treatment), and whether disorder has any impact on functioning today.**

[2] **Please add additional separate documents for elaboration or clarification if the space provided is insufficient.**

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habonimdror@tkz.co.il

C. PHYSICIAN'S STATEMENT

I have completed an examination of _____ whom I have known for _____ years. The results that I have recorded represent, to the best of my knowledge, the participant's complete medical history and my findings on examination. I understand that the program organizers will rely on my report for the decision of participation in the program.

❖ PHYSICAL ASSESSMENT **(please tick FIT or UNFIT)** **[ ]** FIT **[ ]** UNFIT

remarks/restrictions/recommendations _____

_____

_____

❖ MENTAL ASSESSMENT **(please tick FIT or UNFIT)** **[ ]** FIT **[ ]** UNFIT

remarks/restrictions/recommendations _____

_____

_____

_____ _____ _____

Name of Physician [in clear print] **Signature & Stamp** **Date [d/m/y]**

+_____ _____

Telephone **Address [in clear print]**

D. PARTICIPANT'S STATEMENT

I hereby certify that to the best of my knowledge, this medical form is complete in all its details and I fully realize that any condition, mental or physical, that I am found to have, originating prior to the beginning of the program, and which is not described in full in this form or in an 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 nor liability arising out of such a condition. All medication that I take regularly is at my own expense, and has been detailed on this form or accompanying letter. 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 (even if NOT covered by the Medical Insurance).

_____ _____ _____

Name of participant **Signature** **Date [d/m/y]**

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