APPLICATION

מכללה ירושלים

MICHLALAH JERUSALEM COLLEGE

U.S. OFFICE: FRIENDS OF MICHLALAH ■ 9 SUTTON ROAD, MONSEY, N.Y 10952
PHONE: 845.356.0664 ■ FAX: 845.356.0787 ■ EMAIL: MICHLALAHUSA@AOL.COM

STUDENT/PARENT MEDICAL AFFIRMATION

We, the undersigned, affirm that all the information in the attached medical report is accurate and reflects the true physical and emotional health of the applicant.

We have provided the medical report to the primary physician and included all other relevant information from any other physical or mental health professional that has treated the applicant in the last six years.

NAME OF APPLICANT: (PLEASE PRINT) ______________________________

APPLICANT SIGNATURE: ______________________________

SCHOOL CURRENTLY ATTENDING: ______________________________

PHONE NUMBER: ______________________________

PARENT'S NAME: (PLEASE PRINT) ______________________________

PARENT'S SIGNATURE: ______________________________

PHONE NUMBER: ______________________________

CELL: ______________________________

COMMENTS: ______________________________

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Thank you for your cooperation.

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MEDICAL REPORT

To the examining physician: *Your health evaluation is an essential part of the application for participation in a year of study in Israel. Please bear in mind that our mountainside campus is at an elevation of 3,000 feet. Also, walking tours, sometimes strenuous, are an integral part of our academic program. The final decision concerning the applicant's eligibility insofar as physical and emotional health are concerned, will be based on this report. Please make a complete examination with the program in mind. Please note: The health insurance company in Israel requires that this Michlalah medical form be filled out in order to issue coverage.*

1. Name of Applicant: ____________________

2. Address: ____________________

3. Height: __________ Weight: __________ Blood Pressure: __________

	Normal	Abnormal		Normal	Abnormal
Eyes			Teeth, Gums		
Ears			Skin		
Nose			Scalp		
Throat			Glands		
Heart			Orthopedic		
Lungs			Posture, Feet		
Abdomen			Nervous System		
Hernia			Thyroid		
Nutrition			Scoliosis		
Other			Other		

4. Past or present illnesses, operations or severe injuries. Please give dates, complications and any residual symptoms:

   A. Asthma, allergies, food allergies. Please record causative factors: ____________________

   B. Diabetes Mellitus: ____________________

   C. Eating Disorders: (i.e. anorexia, bulimia) ____________________

   D. Disorders of Menstruation: ____________________

E. Migraine, severe headaches or dizzy spells: ______________________

F. Epilepsy, fainting spells: ______________________

G. Respiratory diseases: (chronic bronchitis, bronchiestasis, sinus disease) ______________________

H. Other: ______________________

5. Is applicant receiving any medication? If so, please attach a statement of such medication with dosage and directions for the counselor of the group to keep on file.

____

6. Please indicate any allergy to medication. (i.e. Penicillin, etc.)

____

7. Please give date of last tetanus injection. ______________________

8. Bearing in mind the various conditions imposed by an intensive foreign study program, (lengthy absence from home, adjustment to a foreign culture, changed living conditions, new social contacts) please give us your evaluation of the applicant's emotional stability.

____

9. To your knowledge, has the applicant been treated by a psychiatrist or psychologist?
   - ❑ No
   - ❑ Yes. Please elaborate on a separate sheet of paper indicating the condition, medication and suggestions for participation in the overseas program.

10. I have examined the above-named applicant and,
    - ❑ I consider her physically & emotionally qualified to participate in the year of study in Israel.
    - ❑ I do not consider her physically and emotionally qualified to participate in the year of study in Israel.

11. Comments: ______________________

Name of Physician (please type or print) ______________________

Signature ______________________ Date ______________________

Address ______________________

Phone ______________________ Fax ______________________

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IMMUNIZATION RECORD

The following immunizations are required:

4 DPT, 4 OPV and 2 MMR.

(Hepatitis immunization recommended.)

NAME: ______________________________

PHONE: ______________________________

BIRTH DATE: ______________________________

SCHOOL: ______________________________

	DATE	DATE	DATE	DATE	DATE
DPT					
OPV					
MMR					
HBPV					
Tuberculin					
DT					
Other					