NOTES TO THE EXAMINING PHYSICIAN:

The new and strenuous environment each participant will face on a Birthright Israel: Canada Israel Experience trip takes his/her physical and psychological capabilities to the fullest. The program in Israel is very demanding, requiring early wake-up and participation in a daily average of 15 hours of programming which can include physically strenuous activity such as hiking. It is therefore imperative, as a safeguard to the health of the participant, that this report be as complete and precise as possible.

It is recommended that this form be completed by a physician or nurse practitioner who has known the applicant for at least 12 months, however this is **not mandatory**. If this is not possible, the applicant can have the form completed at a walk-in clinic – *provided the applicant is not currently taking any prescription medication of any kind (excluding Contraception).*

An applicant who has been under the care of a specialist (for example, cardiologist, neurologist, psychiatrist or gastro specialist) may be asked to submit an Additional Note**,** confirming that the applicant will be able to fully participate in the demanding itinerary with hours of walking/hiking each day, early mornings and late nights, etc..

This form will be provided at the discretion of the Canada Israel Experience office.

If any changes take place to the participant's health after this form has been submitted, the participant must submit, before departure, an explanatory medical letter, detailing diagnosis, prognosis and treatment. Failure to submit such a letter can result in expulsion of the applicant from his/her program without any refund.

PLEASE EVALUATE THE APPLICANT'S MEDICAL CONDITION IN LIGHT OF THE FOLLOWING FACTORS THAT DESCRIBE THE PROGRAM:

Social Environment: Participants will be living in a communal environment. They will be sleeping in a dormitory or sharing living quarters with many other people and eating in communal dining facilities.

Activity: The participants will be expected to participate in extensive tours of the country, which will include walking long distances, climbing, hiking, swimming and other strenuous activities.

Medical Facilities: The physician should also bear in mind that medical facilities available for participants will cover only acute illnesses and accidents. There are no facilities available for the treatment of chronic disturbances. Medical care will very often be entrusted to fully trained para-medical personnel, although a doctor will always be available and on call, as will the local hospitals. In some cases, the patient will be transferred to Jerusalem for specialized medical treatment when necessary, and, where indicated, will later be returned to the country of origin for further treatment.

Canada Israel Experience (CIE) intends to rely on this completed form and supplementary forms in making determination of acceptance for or continuation of the applicant in the program. **Omissions or mis-statements are at the risk of the applicant and his/her physician, surgeon, psychiatrist, psychologist or social worker.** CIE may be in contact with the participant's physician should there be any questions or concerns prior to or during the trip.

Should any participant upon arrival in Israel, or during his/her stay, be found to be suffering from any condition, psychological or physical, that is not fully disclosed in this medical form or in an accompanying letter from a qualified medical or psychological professional, then:

- He/she may, at the sole and absolute discretion of CIE or its representatives in Israel or in Canada, be returned to his/her place of origin at the participant's own expense (and there shall be no refund on monies paid for the program.)
- CIE and its representatives in Canada and in Israel are thereby released from responsibility or liability of any kind whatsoever arising out of any aspect of such participant's medical history and mental or physical condition.
- ***ALL SECTIONS WILL BE TREATED CONFIDENTIALLY***

NAME OF PARTICIPANT (print)**:**_____**DATE:** _____

DATE OF BIRTH: _____ **TELEPHONE:** _____
mm/dd/yyyy

Month applied for: May June July August

If completed at a walk-in clinic, indicate name of clinic: _____

PHYSICAL EXAMINATION:

Weight:	Height:	Respiration:	Hearing:	Blood Pressure:	Vision:
Pulse:	Cardiac:	Any Abnormal Findings:			

PSYCHOLOGICAL EXAMINATION:

1. Is the participant currently involved in or has been under psychological therapy of any kind in the past two (2) years?
   YES / NO If yes, with whom?

   _____ Psychiatrist _____ Psychologist _____ Counselor _____Social Worker _____Dietitian

   Year started treatment_____ Ongoing? (circle one:) Yes No

   Frequency of therapy _____ Year ended treatment_____

2. If **yes** was answered to #1, please describe the nature of therapy:

PRESCRIPTION MEDICATIONS:

Please list all medications patient is currently taking (continue on back if necessary):

Medication:	Pharmacological Name & Dosage:	For Treatment Of:	How long patient been on Meds:
1.			
2.			
3.			

Are you the prescribing physician of these medications? Yes No

If Yes, in your professional opinion, is the applicant stable on each of these medications?_____

Is patient currently taking any vitamins/supplements? Yes No
If yes, which one(s)?_____

Reason for intake? _____

ALLERGIES:

Participants are responsible for carefully choosing their food on the trip and avoiding foods to which they are allergic

Allergic to:	Description of reaction & medication(s) required

Does patient require an Epi-pen? Yes ____ No ____ If Yes, CIE requires a minimum of three (3) on trip.

MEDICAL CONDITIONS:

Please check any medical conditions which currently apply to patient, or have been an issue in the past year:

Arthritis	**Asthma**	**Dizziness**
Frequent Ear Infections	**Fainting**	**Eating Disorder**
High/Low Blood Pressure	**Frequent Headaches/Migraines**	**Epilepsy**
Pneumonia	**Gastrointestinal Problems**	**Kidney Problems**
Thyroid Disorder	**Heart Problems**	**Pneumonia**
Vision Problems	**Illegal Drug Use**	**Sexually Transmitted Diseases**
Whopping Cough	**Nut Allergies**	**Sleep Disorder**

VACCINATIONS:

While **not mandatory**, it is important to know if you have received your immunizations as there can be outbreaks, even in Israel, and we would not want you to become ill as a result of contracting one of these vaccine-preventable diseases. If you have had a Tetanus vaccine in the last 10 years this can prevent you from needing a vaccination in Israel if you get a laceration that requires medical attention.

Tetanus: ____ Date: _____

PHYSICIAN STATEMENT:

I have read the "Notes To Examining Physician" on the cover of the examination form and thereafter have examined

_____ whom I have known for _____ years.
Name of applicant

NOTE TO PHYSICIAN: The new and strenuous environment each participant will face on a Birthright Israel: Canada Israel Experience trip takes his/her physical and mental capabilities to the fullest. The program in Israel is very demanding, requiring early wake-up and participation in a daily average of 15 hours of programming. It is therefore imperative, as a safeguard to the health of the participant, that this report be as complete and precise as possible. **If the participant has any previous mental health diagnoses, we ask you to please carefully evaluate the effect that the stress (i.e. physical pace of the trip & continued lack of sleep) and change in environment would have on their mental health.**

I recommend full activity in:

a) long hours of walking & hiking per day oYes oNo If no, explain:

b) FULL participation in programming with very limited sleep oYes oNo, If no, explain:

(6 hours per night)

c) communal living; sharing living quarters with strangers oYes oNo If no, explain:

d) ***I recommend certain restrictions***: oYes please specify o No

e) ***I recommend a special diet:*** oYes please specify o No

Omissions or mis-statements are at the risk of the applicant and his/her physician, surgeon, psychiatrist, psychologist or social worker.

Notes/Comments:

_____
_____

The results I have recorded represent, to the best of my knowledge, all of the participant's medical history and my findings on examination. I understand that the program organizers in Israel will rely on my report and findings. In my opinion the participant is physically, mentally and emotionally capable of participating in the program as outlined in "Notes To Examining Physician" on Page 1 of these forms.

Name of Physician or Nurse Practitioner: *(*print clearly*)* _____

Phone: (___)_____ Address/City: _____

X_____ _____
Signature of Physician or Nurse Practitioner Provincial License Number

PARTICIPANT STATEMENT:

I have read the "Notes To Examining Physician" on the Medical Examination Form. I hereby certify that, to the best of my knowledge, this medical form is complete in all of its details and fully realize that any condition, mental or physical, that I am found to have, originating prior to my arrival in Israel, and which is not described in full in this form or in any 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 or liability arising out of such condition. I also realize that medical coverage does not include dental or optometry treatment.

If you have any food allergies/sensitivities, you are responsible for carefully choosing your food on the trip and avoiding foods to which you are allergic/sensitive. While we will do our utmost to accommodate specific food allergies/sensitivities, please be aware that Israel does not have the same level of allergy awareness as is common in North America and CIE cannot guarantee that your allergy can be completely accommodated. Please call our office to discuss your specific situation with our Registration Manager.

All medication that I take regularly is at my own expense. This has been detailed on this form or accompanying letters. 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. Furthermore, I understand that I am required to complete the online medical information at www.cieregistration.com, as well as purchase **mandatory** additional Travel Medical Insurance.

I hereby give permission for CIE to contact my physician/healthcare provider with any questions about my health prior to or during the trip.

If any changes take place in your health after this form has been submitted, you must submit, before departure, an explanatory medical letter detailing diagnosis, prognosis and treatment. Failure to submit this information may result in your expulsion from this program **without any refund**.

MUST BE COMPLETED BY PARTICIPANT:

I, _____, hereby certify that all information disclosed on this
Applicant Name (**please print**)

form is complete & accurate. Failure to disclose any or all medical information **WILL** result in my immediate removal from my trip at my own expense.

Applicant Signature _____Date (mm/dd/yyyy): _____

How To Send The Completed Dr Form:
SCAN AND E-MAIL TO CIEC@UJAFED.ORG with your First and Last Name on the Subject Line.

**Should this form need to be presented at a medical facility in Israel, be sure to keep a digital copy of this form in your email sent files **