



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.

The Additional Note will be sent to the applicant 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: _____ **PHONE NUMBER:** _____
mm/dd/yyyy

If this was completed at a walk-in clinic, please 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 **six (6)** months?

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 MEDICATION(S): Please list all medications patient is currently taking:

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 you are the prescribing doctor, in your professional opinion, is the patient stable to travel overseas with 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 chronic medical conditions which currently apply to patient, or has been an issue in the past year:

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

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 Yes No If no, explain:

b) FULL participation in programming with very limited sleep Yes No, If no, explain:

(6 hours per night is standard)

c) communal living; sharing living quarters with strangers Yes No If no, explain:

d) **I recommend certain restrictions:** Yes please specify No

e) **I recommend a special diet:** Yes please specify 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 Upload The Signed Dr. Form:

1. Save the Form to your Computer
2. Upload the Form to your STEP 2 CIE Registration Account: upload.cieregistration.com, using your STEP 2 login credentials.