MEDICAL FORM

This page is to be completed by student

All information will remain strictly confidential and will only be used by medical providers in case of medical necessity while the student is in the school. Students with pre-existing health conditions must have medical insurance/coverage or proof of ability to pay for any necessary medical treatment and medication. If there's a medical condition that affects one's attendance of classes, she will need to return home to care for her health. By signing this form you agree to pay for any costs associated with health care that may not be covered by your insurance should Machon Chana's staff determine you are in need of such.

Name of Student: _____ Date of Birth: _____

In case of emergency contact:

Name: _____ Relationship to you: _____

Address: _____

City: _____ State: _____ Zip/ Postal code: _____

Country: _____ Phone #: _____ Mobile Tel: _____

1. Do you have any special dietary requirements?

2. Do you now or have you ever suffered from an eating disorder? Please provide details:

3. Have you ever received psychological counseling? If yes please provide details:

4. Do you suffer from any mental or emotional illnesses? If yes please detail:

5. Do you suffer from any allergies? If yes please list:

6. Do you suffer from asthma, eczema or hives? If yes, please detail:

7. Do you suffer from any of the following:

Tuberculosis	❑ No	❑ Yes	diabetes	❑ No	❑ Yes
Epilepsy	❑ No	❑ Yes	digestive tract diseases;	❑ No	❑ Yes
Heart diseases	❑ No	❑ Yes	such as chronic constipation or diarrhea		
Respiratory illnesses	❑ No	❑ Yes	any other significant illnes	❑ No	❑ Yes

8. Please list any hospitalizations and surgeries you have undergone:

9. Do you have any physical limitations? If yes please describe:

10. Do you take any medication(s)? If yes please list name of medication(s) and reason for use:

11. Are you allergic to any medication(s)? If yes please indicate which medication(s):

12. Is there anything else you feel we should know about your health?

I have read the above and affirm that all information contained in this application is true and accurate to the best of my knowledge. Falsifying or purposefully leaving out any information on this medical form is cause for immediate expulsion from Machon Chana school and dorm, as well as cancellation of the student visa in the case of foreign students. If there is medical information that a prospective student deems extremely confidential and does not wish to write on this form it must be discussed orally with Rabbi Majeski at the time of the interview.

Applicant's Signature _____ Date _____

MEDICAL REPORT

Machon Chana Women's Institute

Name _____ Date of Birth _____

Address _____ Country _____

Telephone Number _____ Mobile Phone Number _____

Medical Examination to be completed by Physician

Weight _____

Height _____

Any recent findings in any of the following areas:

Eyes	❑ No	❑ Yes	Heart	❑ No	❑ Yes
Ears	❑ No	❑ Yes	Lungs	❑ No	❑ Yes
Nose	❑ No	❑ Yes	Nervous system	❑ No	❑ Yes
Mouth, Throat	❑ No	❑ Yes	Orthopedic	❑ No	❑ Yes
Skin	❑ No	❑ Yes	Speech	❑ No	❑ Yes

If checked "yes" to any of the above, please specify:

Is the student currently receiving any medications? If yes, please attach statement of such medications with dosage and directions.

List any medications and reason for medication, the students has taken regularly over the last three years:

Does the student have any physical limitations? ❑ No ❑ Yes If yes, please describe:

Date of last tetanus immunization:

I have examined the above named student and consider her physically and emotionally able to participate in a full-time learning program.

Name of Physician (please print clearly): _____

Address: _____

Phone: _____

Signature of Physician Date

To the best of my knowledge, all the above information is both complete and accurate.

Student Signature Date

Parent/Gaurdian Signature (If student is under 18 years of age) Date