

Machon Chana/Michlelet Chana Medical Report

Name of student: _____ Date of birth: _____
Address: _____ Country: _____
Telephone Number: _____

Medical Examination to be completed by a Physician

Weight: _____
Height: _____

Any recent findings in any of the following areas (please circle):

Eyes	Yes	No			
Heart	Yes	No			
Ears	Yes	No	Lungs	Yes	No
Nose	Yes	No	Nervous System	Yes	No
Mouth/Throat	Yes	No	Orthopedic	Yes	No
Skin	Yes	No	Speech	Yes	No

If circled "yes" to any of the above, please provide details: _____

Is the student currently receiving any medications? If yes, please attach list of medications, dosage and directions. _____

List any medications and reasons for medication, the student has taken regularly over the past three years: _____

Does the student have any physical limitations? If yes, please describe: _____

Date of last tetanus immunization: _____

I have examined the above-named student and consider her physically and emotionally capable of participating in a full-time learning program.

Name of Physician (please print clearly): _____
Address: _____
Phone Number: _____

Signature of Physician

Date

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

Signature of Student

Date

Signature of Parent/Guardian (if student is under 18 years of age)

Date