

OTZMA Personal Health History

(To be completed by applicant)

Name _____ **Gender** _____
Last First M.I.

Permanent Address _____
Number/Street

City State/Province Zip/Postal Code Home Phone

Work Phone Fax E-Mail Address

Family Medical History

Parent 1 Information:

Parent 1 Name (include maiden if applicable) _____

Address _____

City State/Province Zip/Postal Code

Phone (Home) (Cell) (Work)

Parent 2 Information:

Parent 2 Name (include maiden if applicable) _____

Address _____

City State/Province Zip/Postal Code

Phone (Home) (Cell) (Work)

Have any of your immediate family members suffered from any diseases or conditions about which we should be made aware?

Yes No

If yes, please explain _____

Is your biological family history unknown? Yes No

If yes, please explain _____

Are any members of your immediate family deceased? Yes No

If yes, please explain _____

Have you been treated by a mental health professional (psychologist, counselor or psychiatrist)? Yes No

If yes, you are required to submit a letter from your doctor describing the conditions, prognosis and treatment.

Emergency Contact (list someone other than a parent or guardian)

Last	First	M.I.	Relationship to Participant
Address			
City	State/Province	Zip/Postal Code	
Home Phone	Cell Phone	Work Phone	Fax
			E-mail Address

Reminder: "YES" responses DO NOT automatically disqualify for OTZMA. However, failure to disclose your health history is grounds for dismissal from the program. We trust that you will answer these questions honestly and in full. All of the information must be filled out completely and will be treated confidentially.

*** REMINDER: IF, IN THE LAST 5 YEARS, YOU HAVE EVER BEEN UNDER THE CARE OF A SPECIALIST, ARE REQUIRED TO CONTINUE THERAPY OR TREATMENT, OR MUST CONTINUE RECEIVING MEDICATION OR DRUGS, YOU MUST SUBMIT A LETTER FROM YOUR DOCTOR WITH HIS/HER NAME, ADDRESS AND PHONE NUMBER. THIS LETTER SHOULD DESCRIBE THE CONDITIONS, PROGNOSIS, TREATMENT AND ANY RESULTING IMPLICATIONS FOR YOUR PARTICIPATION ON OTZMA. WE WILL NOT PROCESS ANY APPLICATION THAT DOES NOT INCLUDE THIS LETTER.**

Personal Health History

General Medical Information Please check the appropriate box.

Date

- | | | | |
|--|------------------------------|-----------------------------|-------|
| 1. Have you ever been treated for any major physical ailment? | <input type="checkbox"/> Yes | <input type="checkbox"/> No | _____ |
| 2. Do you need special medical, dental, or dietetic services or attention? | <input type="checkbox"/> Yes | <input type="checkbox"/> No | _____ |
| 3. Have you ever had asthma or other allergic disorders? | <input type="checkbox"/> Yes | <input type="checkbox"/> No | _____ |
| 4. Have you ever had surgery or major hospitalization? | <input type="checkbox"/> Yes | <input type="checkbox"/> No | _____ |

If you have answered "Yes" to any of the above, please list dates and briefly explain in the space provided below.

Health Record Please check the appropriate box. Check "Yes" if you have ever had or currently have any of the following:

- | | | | | | |
|--|------------------------------|-----------------------------|--|------------------------------|-----------------------------|
| 1. Accidents/fractures | <input type="checkbox"/> Yes | <input type="checkbox"/> No | 22. Headaches or migraines | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| 2. ADD | <input type="checkbox"/> Yes | <input type="checkbox"/> No | 23. Heart trouble | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| 3. ADHD | <input type="checkbox"/> Yes | <input type="checkbox"/> No | 24. Hernia | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| 4. Alcohol or drug use | <input type="checkbox"/> Yes | <input type="checkbox"/> No | 25. Inflammatory bowel disease | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| 5. Allergies | <input type="checkbox"/> Yes | <input type="checkbox"/> No | 26. Insect sting reactivity | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| 6. Appendectomy | <input type="checkbox"/> Yes | <input type="checkbox"/> No | 27. Irritable bowel syndrome | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| 7. Arthritis | <input type="checkbox"/> Yes | <input type="checkbox"/> No | 28. Kidney trouble | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| 8. Asthma | <input type="checkbox"/> Yes | <input type="checkbox"/> No | 29. Lactose intolerance | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| 9. Bronchitis | <input type="checkbox"/> Yes | <input type="checkbox"/> No | 30. Medication intolerance | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| 10. Cancer | <input type="checkbox"/> Yes | <input type="checkbox"/> No | 31. Medication intolerance | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| 11. Chicken pox | <input type="checkbox"/> Yes | <input type="checkbox"/> No | 32. Operations | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| 12. Cigarette smoking or other tobacco use | <input type="checkbox"/> Yes | <input type="checkbox"/> No | 33. Pneumonia/chronic bronchitis | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| 13. Convulsions or seizures | <input type="checkbox"/> Yes | <input type="checkbox"/> No | 34. Recurrent back pain | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| 14. Depression | <input type="checkbox"/> Yes | <input type="checkbox"/> No | 35. Severe or recurrent abdominal pain | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| 15. Diabetes | <input type="checkbox"/> Yes | <input type="checkbox"/> No | 36. Sleep walking | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| 16. Ear infections | <input type="checkbox"/> Yes | <input type="checkbox"/> No | 37. Tuberculosis or positive TB test | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| 17. Eating disorder/self-induced vomiting | <input type="checkbox"/> Yes | <input type="checkbox"/> No | 38. Ulcer | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| 18. Endocrine disorder | <input type="checkbox"/> Yes | <input type="checkbox"/> No | | | |
| 19. Eye trouble | <input type="checkbox"/> Yes | <input type="checkbox"/> No | | | |
| 20. Fainting | <input type="checkbox"/> Yes | <input type="checkbox"/> No | | | |
| 21. Frequent colds | <input type="checkbox"/> Yes | <input type="checkbox"/> No | | | |

If you have answered "Yes" to any of the above, please list dates and briefly explain in the space provided below. (Indicate by number)

Do you use corrective eyewear? Yes _____ No _____

If so, please copy your prescription here

Eyeglasses: Right _____ Left _____

Contact Lenses: Right _____ Left _____

Immunization History

Required Vaccinations

MMR (Measles, Mumps, Rubella) Vaccine Dates #1 _____ #2 _____ (two doses required)

Polio Vaccine Dates _____

Tetanus/Diphtheria Vaccine Dates _____

(In order to be effective, your last booster must have been administered within the past 10 years!)

Tuberculin test (Mantoux only) Date Placed _____ Date Read _____

Result: Positive _____ Negative _____

(In order to be effective your last TB test must have been administered within the past 12 months!)

Hepatitis A Vaccine Dates: #1 _____ #2 _____

Hepatitis B Vaccine Dates: #1 _____ #2 _____ #3 _____ (three doses required)

Chicken Pox Vaccine (Recommended, if no history of disease) Date _____

Are you taking any medication now? If so, please state names and the conditions.

Please sign below indicating that you have read this statement and sign below indicating that you understand it completely.

APPLICANT'S STATEMENT

I hereby certify that, to the best of my knowledge, the above medical form is complete in all its details, and I fully realize that any condition, mental or physical, that I am found to have that originated prior to my arrival in Israel, and which is not described in full in this form or in any accompanying letter, could be due cause for my dismissal in the program, or treatment in Israel solely at my expense, and that the OTZMA program and its representatives in Israel have neither responsibility nor liability arising out of such conditions.

I also realize that the medical coverage provided by OTZMA is limited and does not include dental treatment of any form whatsoever, or eyeglasses. All medications that I take regularly are at my own expense, and have been detailed in this form and in accompanying letters. I 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 OTZMA representatives in Israel. I am aware that usage or involvement with illegal drugs or narcotics or any other anti-social behavior may be cause for immediate dismissal from the program, and that I may be responsible for any tuition and travel expense back home.

I, _____, give permission to OTZMA and the agents thereof to contact the aforementioned individual(s) for the purpose of obtaining necessary information to assist in the selection process for OTZMA.

Name of Applicant _____

Signature of Applicant _____ Date _____

Please read and give this page to your doctor

Medical Examination Guidelines

OTZMA requires that all applicants have a complete physical examination as part of the application process. Only information from physical exams conducted during this academic year (beginning September 2009) will be acceptable. Applicants should complete the Personal Health History as possible prior to the physical examination. Applicants must then submit the completed Personal Health History to their physician for completion of the Physical Examination Form.

The physical exam must be conducted by a licensed physician who is not related to the applicant. Only complete Physical Examination Forms will be accepted. Upon finishing the physical exam, the physician must complete the enclosed Physical Examination Form. Applicants should instruct their physicians to return the full medical form directly to them. The applicant is responsible for returning the full medical form in his/her application packet so all appointments must be made to coincide with application deadlines.

Health-Related Program Details

Because each participant will face many physical and mental challenges on OTZMA, it is imperative, as a safeguard to the health of the participant, that the medical form be as complete and precise as possible. There are, therefore, several important elements of the program that the physician should keep in mind while completing the medical form:

- The climate in Israel is mostly dry, with semi-arid conditions over a large part of the country. Participants will be touring and working in temperatures that often reach 100 degrees Fahrenheit in the shade.
- The living conditions for OTZMA participants will be in a communal setting. They will often be sleeping in dormitory-style housing

and eating in communal dining facilities.

- Work assignments for participants may include physical labor in the sun, factory, or communal kitchen.
- Each participant will be expected to take part in a number of tours around Israel which include walking long distances, climbing, and other potentially strenuous activities.
- Participants move to new assignments approximately once every two to three months. This requires the maturity and mental stability to make smooth transitions and deal with last minute changes in assignments.



Physical Examination

(To be completed by a licensed physician upon examination)

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Height _____ Weight _____ Pulse _____ B.P. _____ Hb. _____ Hct. _____

Urinalysis: Specific gravity _____ Sugar _____ Alb. _____ Micro. _____

(N = Normal. Check if abnormal and explain)

General Build	_____	Breasts	_____	Pelvic (if appropriate)	_____
Head	_____	Abdomen	_____	Rectal (if appropriate)	_____
Ears	_____	Genitalia	_____	Neurological	_____
Eyes	_____	Hernia	_____	Psychological	_____
Teeth	_____	Up Extremities	_____	Hearing	_____
Mouth	_____	Lower Extremities	_____	Right _____ Left: _____	
Throat	_____	Inguinal Rings	_____		
Chest	_____	Spine	_____		
Lungs	_____	Musculoskeletal	_____		
Heart	_____	Lymph Glands	_____		

Restrictions(s), if any:

Note: Please be sure to enclose supporting information if the applicant has any past or ongoing health problems.

PHYSICIAN'S STATEMENT

I have read the Medical Examination Guidelines and program details and, thereafter, have examined the applicant. I have recorded the results above, which represent to the best of my knowledge, the applicant's medical history and my findings upon examination. I certify that the applicant's immunization is current. If I become aware of a change in the applicant's medical condition, I will notify: OTZMA, United Jewish Communities, 111 Eighth Avenue, Suite 11E, New York, NY 10011, 1.877.GO.OTZMA (466.8962), otzma@ujc.org.

In my opinion, the applicant is capable incapable (check one)
of participating in the program as outlined in the Guidelines and program details.

I have known the applicant for _____ years. I am not related to the applicant.

To the best of my knowledge, the information on pages 1, 2, and 3 is correct. I understand that the OTZMA program and its representatives in Israel will rely on my above report and findings.

Name

Address

Telephone Number

E-mail Address

Stamp and Signature

License Number

Date