Australasian Zionist Youth Council

| | |
|---|---|
| Full Name | |
| Movement | |

# SHNAT 2023
# MEDICAL FORM

**PRIVATE & CONFIDENTIAL**

**Please return all 12 pages (including this page) to shnat@azyc.com.au**

# PLEASE READ

## For the Parent and the Participant:

Thank you for your application to the AZYC Shnat Program ("**Program**").

Before submitting this medical form, please ensure that.

- you and your physician have read this whole medical form;
- your physician has completed pages 4 to 12 (inclusive) of this medical form;
- you have completed page 13 of this medical form;
- you have obtained a letter from any specialists that you have been under the care of. This letter should include diagnosis, treatment and should approve your travel on the Program. This may include, for example, cardiologists, neurologists, psychiatrists, psychologists and social workers; and
- **Please note: If you have seen a psychologist, psychiatrist, counsellor or other licensed mental health professional ("Mental Health Professional") in the last 2 years, as a condition of participating on the Program, you must acquire a letter from the Mental Health Professional that you are suitable to partake in the Program. .**
- you have obtained a letter from your physician or specialist detailing any prescription medication that you will be taking during your time away on the Program, a copy of which you will require when traveling through international customs.

This form will be used by coordinators and leaders in Israel to assist in the smooth running of the Shnat experience. A copy will be given to all participating Organisations so that they may understand each participant's medical conditions.

As such, it is important that this document is filled in completely, accurately and honestly. Compiling this document allows the AZYC and all participating Organisations to give all participants the healthiest and most enjoyable experience possible.

If any changes take place in the Participant's condition within the last ten days before departure, the Participant must submit, before departure, an explanatory medical letter detailing diagnosis, prognosis, treatment and confirmation that the Participant is fit to attend the Program. Failure to submit such a letter shall result in expulsion of the applicant from the Program without any refund.

There have been previous instances where a medical form has not been filled in completely and honestly, and a participant has subsequently been sent home from the Program due to that participant's unsuitability.

ALL INFORMATION PROVIDED IS KEPT STRICTLY CONFIDENTIAL BETWEEN THE PARTICIPATING ORGANISATIONS.

## Notes to the Examining Physician:

Pages 4 to 12 of this form must be completed by a physician who has known the Participant for at least 12 months prior to the filling out of this form.

In addition, any participant who has been under the care of a specialist (for example, cardiologist, neurologist, psychiatrist, psychologist, social worker, etc.) must submit a written detailed report from this specialist giving complete diagnosis, prognosis, evaluation, approval for international travel and confirmation that the Participant is fit to attend the Program.

The Program can be a strenuous experience due to the intensity of the activities and the communal lifestyle that the Participant will inevitably face. As such, we kindly ask you to detail your thoughts on the suitability of the applicant living under the following conditions:

1 During the Program there will be periods the Participant will be living a communal form of life. The Participant will be sleeping in a dormitory with other people and eating in a communal dining hall.

2 Program activities may include strenuous physical work in the sun, perhaps on a farm, or otherwise work in the communal kitchen with all the epidemiological problems involved. They will also be expected to participate in a number of tours of the country, which may involve hiking long distances, climbing and other similar activities.

If the Participant is required to continue receiving medication while under the auspices of the Program, then the Participant must include a medical letter giving full details. Since very often medicine is not available under the same trade name as in the country of origin, the full pharmacological name of all medicines and drugs used by the Participant should be given. Please specify dosage, and distinguish clearly between regular and occasional medication and the circumstances in which the latter may be required. In any event, the Participant should bring an extra supply of the required medicine on the Program, some of which should be entrusted to the group leader.

All information is kept confidential between the participating Organisations. This medical form will be in the possession of the group leaders throughout the program in Israel.

Please feel free to contact me if you have any queries about this form or more specific details on the nature of activities usually conducted on the Program.

Kind regards,

Morgan Rothschild

National Chairperson, Australasian Zionist Youth Council (AZYC)

Mobile: 0408 168 058

Email: azyc@azyc.com.au

**PLEASE REFRAIN FROM USING ANY MEDICAL ABBREVIATIONS**

**Participant Name:**

**PAGES 4 TO 12 OF THIS MEDICAL FORM TO ONLY BE COMPLETED BY THE EXAMINING PHYSICIAN**

Please tick if any of the following applies to the Participant and include details where necessary.
If supplied space is insufficient, please attach additional pages.

| Respiratory | | |
|---|---|---|
| | Yes | No |
| Bronchitis | | |
| Asthma | | |
| Pneumonia | | |
| Tuberculosis | | |
| Other (if yes, please specify) | | |

| Urogenital | | |
|---|---|---|
| | Yes | No |
| Kidney Disease | | |
| Other (if yes, please specify) | | |

| Cardiovascular | | |
|---|---|---|
| | Yes | No |
| Heart / Valvular Disease | | |
| Hypertension | | |
| Circulation Problems | | |
| Rheumatic fever | | |
| Other (if yes, please specify) | | |

| Endocrine | | |
|---|---|---|
| | Yes | No |
| Diabetes | | |
| Thyroid Disease | | |
| Other (if yes, please specify) | | |

| Gastro-Intestinal | | |
|---|---|---|
| | Yes | No |
| Inflammatory Bowel Disease | | |
| Other (if yes, please specify) | | |

| Neurological | | |
|---|---|---|
| | Yes | No |
| Headaches | | |
| Any seizure disorder | | |
| Fainting | | |
| Glasses | | |
| Intellectual Disabilities | | |
| Other (if yes, please specify) | | |

| Dermatological | | |
|---|---|---|
| | **Yes** | **No** |
| Acne requiring treatment | | |
| Other (if yes, please specify) | | |

| Musculoskeletal | | |
|---|---|---|
| | **Yes** | **No** |
| Any functional disabilities | | |
| Any significant joint disease | | |
| Other (if yes, please specify) | | |

| Mental Health | | |
|---|---|---|
| | **Yes** | **No** |
| Eating disorders (including excessive dieting | | |
| Obsessive Compulsive Disorder | | |
| Depression | | |
| Psychotic illness | | |
| Personality disorder | | |
| Stress problems | | |
| Bipolar Disorder | | |

| Immunologic al | | |
|---|---|---|
| | **Yes** | **No** |
| Chronic Fatigue | | |
| Glandular Fever | | |
| Other (if yes, please specify) | | |

| Allergies | | |
|---|---|---|
| | **Yes** | **No** |
| Medicine Allergies | | |
| General Allergies (If yes, please specify) | | |
| Epipen Required | | |

| Dietary restrictions | | |
|---|---|---|
| | **Yes** | **No** |
| Vegetarian | | |
| Vegan | | |
| Lactose intolerant | | |
| Gluten intolerant | | |
| Fructose intolerant | | |
| Other (if yes, please specify) | | |

**Please specify any medical problems not listed above:**

| |
|---|
| *(where not applicable please mark N/A)* |

**Please give details concerning diseases, allergies or conditions to which 'YES' has been answered above, including names and addresses of relevant physicians and hospitals, any relevant dates and any relevant treatments:**

| |
|---|
| *(where not applicable please mark N/A)* |

**Please provide details of any infectious diseases suffered in the past three (3) years (for example, glandular fever), including dates and treatment information:**

| |
|---|
| *(where not applicable please mark N/A)* |

**Please detail any operations or serious injuries sustained in the past five (5) years, including dates and treatment information:**

| |
|---|
| *(where not applicable please mark N/A)* |

**Please detail any recurring illnesses and any other significant ill health in the past five (5) years, including dates and treatment information:**

| |
|---|
| *(where not applicable please mark N/A)* |

**Please detail any relevant family issues (health issues or otherwise) (which you feel are appropriate to disclose) that have occurred in the past three (3) years (for example, divorce, recent bereavement, emotional stress), including dates (if applicable):**

| |
|---|
| *(where not applicable please mark N/A)* |

**Please detail counselling, psychotherapy or other psychological help that the applicant has sought in the past (including dates, treatments, and reasons for consultation, if applicable):**

| |
|---|
| *(where not applicable please mark N/A)* |

**Please detail all medications the applicant is currently taking, and has taken for the past two (2) years (including: all alternative therapies, vitamins, herbal remedies and non-prescription medication; and the frequency, dosage and reason for the treatment):**

| |
|---|
| *(where not applicable please mark N/A)* |

**Please detail whether the Participant has suffered from the following diseases:**

| | Yes | No |
|---|---|---|
| Chicken Pox | | |
| Measles | | |
| Mumps | | |
| Rubella | | |

**Vaccination history (including dates of vaccinations):**

| | |
|---|---|
| Tetanus | |
| Hepatitis A | |
| Hepatitis B | |
| Whooping Cough | |
| Sabin Vaccine (Polio) | |
| Measles/Mumps/Rubella | |
| Other – please specify | |

**Is full strenuous activity possible?** Yes / No (please circle one) Please provide details of opinion:

*(where not applicable please mark N/A)*

**Please detail any previous consultations to medical practitioners by the Participant within the previous five (5) years, not already detailed here, including any details that may be relevant to overseas medical practitioners (for example, any helpful knowledge in the case of serious emotional difficulty, an accident or other serious medical issue).**

*(where not applicable please mark N/A)*

## Physical Examination

Weight _____ Height _____ Blood Pressure _____

Pulse _____ Respiratory Examination _____

Hearing _____ Vision _____

Any findings to note: _____

_____

_____

| | | | |
|---|---|---|---|
| Head | | | |
| General build | | | |
| Neck | | | |
| Ears | | | |
| Eyes | | | |
| Teeth | | | |
| Mouth, throat | | | |
| Chest, lungs | | | |
| Heart | | | |
| Vascular system, BP | | | |

| | | | |
|---|---|---|---|
| Abdomen & viscera | | | |
| G.I. system | | | |
| U.G. system | | | |
| Upper extremities | | | |
| Lower extremities | | | |
| Spine | | | |
| Skin | | | |
| Nervous system | | | |
| Mental & psychological state | | | |

**PHYSICIAN'S STATEMENT**

I have read the "Notes to the Examining Physician" on the cover of the examination form and thereafter have examined the Participant, _____, whom I have known for _____ years. I have good knowledge of the Participant and his/her medical reports, and hereby certify that the details given in the form are complete and correct.

The results I have recorded represent, to the best of my knowledge, all of the Participant's medical history that has been requested. I understand that the Program organisers will rely on my report and findings. In my opinion the Participant is physically, mentally and emotionally capable of participating in the Program.

**I recommend full physical activity (including outdoor adventure activities):**

Yes / No (please circle one)

Please provide details of opinion:

*(where not applicable please mark N/A)*

**I recommend certain restrictions:**

Yes / No (please circle one)

Please provide details of opinion:

*(where not applicable please mark N/A)*

**In my opinion, _____ is / is not** (please circle) **capable of participating in the Program as outlined.**

**SURGERY STAMP**

**Physician's Name (please print):**

**Surgery Address:**

**Telephone number:**

**Signature:** **Date:**

**PARTICIPANT AND PARENT/GUARDIAN OF PARTICIPANT STATEMENT**

We hereby certify that:

1. pages 3 to 10 of this medical form have only been completed by the physician named on page 10 of this medical form;
2. to the best of our knowledge, this **medical form is complete** in all its details;
3. we fully realise that **any condition, mental or physical,** that the Participant is found to have, originating prior to the Participant's departure from Australia, and which is not described in full in this form or in any accompanying letter, will be due cause for the Participant's return to Australia, or treatment in the State of Israel or any other country solely at our expense, and that the Program organisers have **neither responsibility nor liability arising from such condition**.

We realise that the medical insurance provided on this program will not cover pre-existing medical conditions. We also realise that medical coverage does not include dental treatment or any form whatsoever of eyeglasses.

All medication that the Participant takes regularly is at our own expense, and has been detailed on this form or letters. We also give our full permission for all treatment of any nature deemed necessary by doctors in Israel to be extended to the Participant.

**Name of Participant (please print):**

**Signature:**

**Date:**

**Name of Parent/Guardian (please print):**

**Signature:**

**Date:**