



# THE HEBREW UNIVERSITY OF JERUSALEM ROTHBERG INTERNATIONAL SCHOOL



## *Report of Medical Examination*

**The applicant should complete this section.**

**PLEASE TYPE OR PRINT CLEARLY AND BRING A COPY OF THIS FORM WITH YOU TO JERUSALEM.**

Name of Applicant \_\_\_\_\_ Social Security Number \_\_\_\_\_

Please indicate the program to which you are applying \_\_\_\_\_

Address \_\_\_\_\_

E-mail Address \_\_\_\_\_

**The physician should complete the remainder of this report of medical examination.**

**To the examining physician: This form must be completed in full. Questions that are not relevant to the applicant must be answered with a "N/A". An incomplete form will be sent back to the applicant.**

Your health evaluation is an essential part of the application for participation in study abroad programs at the Hebrew University. We require a full physical examination. Please include results of your lab work on this report; do not submit lab reports with this evaluation.

Date of Birth \_\_\_\_\_ Age \_\_\_\_\_ Gender \_\_\_\_\_

**Past or present illnesses (Please give dates, complications, and any residual symptoms):**

A. History of heart disease (valve disorders, congenital malfunctions, etc.) \_\_\_\_\_

B. Rheumatic fever (heart involvement) \_\_\_\_\_

C. Diseases of the digestive tract: (peptic ulcer; biliary tract disease, chronic or recurrent diarrhea, severe constipation, vomiting spells, hernia, appendicitis) \_\_\_\_\_

D. Respiratory diseases (tuberculosis, asthma, chronic bronchitis, bronchiectasis, sinus disease) \_\_\_\_\_

E. Urinary tract diseases (nephritis, nephrosis, calculi, recurrent bladder or prostatic disease, history of urinary tract infection) \_\_\_\_\_

F. Disorders of menstruation (give details) \_\_\_\_\_

G. Diabetes mellitus \_\_\_\_\_

H. Hypertension \_\_\_\_\_

I. Migraine or severe headaches (dizzy spells, strokes) \_\_\_\_\_

J. Epilepsy, fainting spells, history of head injuries \_\_\_\_\_

K. Muscle disease \_\_\_\_\_

L. Allergic diseases (hay fever, food allergies). Please record causative factors \_\_\_\_\_

M. Chronic skin diseases \_\_\_\_\_

N. Severe injuries \_\_\_\_\_

O. Surgeries (list surgeries and dates. If none, write "none") \_\_\_\_\_

P. Systemic disease (juvenile rheumatoid arthritis, lupus, erythematosis) \_\_\_\_\_

Q. Please conduct a complete examination: Height \_\_\_\_\_ Weight \_\_\_\_\_

	Normal	Deviation from Normal
Skin		
Eyes		
Ears		
Hearing		
Nose		
Teeth		
Heart		

	Normal	Deviation from Normal
Lungs		
Abdomen		
Tonsils		
Feet		
Spine		
Blood pressure		
Urinalysis (dipstick & microscopic, if indicated)		

R. List special dietary requirements (i.e., low sodium) \_\_\_\_\_

S. Is the applicant is receiving any medication?

None  As follows: \_\_\_\_\_

Please attach statement of such medication with dosage and instructions to keep on file.

T. What is your evaluation of the applicant's emotional stability (bearing in mind the various conditions imposed by a foreign study program: lengthy absence from home, adjustment to a foreign culture, different living conditions, etc.)

\_\_\_\_\_  
\_\_\_\_\_

U. Please indicate if, to your knowledge, the applicant has been treated by a psychologist or psychiatrist. In such cases, a supporting letter from the treating psychologist or psychiatrist may be requested.

\_\_\_\_\_

V. Restrictions on physical activity, including exercise in a fitness facility:

None  As follows: \_\_\_\_\_

**PLEASE VERIFY THAT ALL QUESTIONS HAVE BEEN ANSWERED BEFORE SIGNING BELOW**

**Physician's Statement (signed and stamped):**

I have examined the above-named applicant and consider him/her physically qualified to participate in study at the Hebrew University.

Name of Physician (please type or print) \_\_\_\_\_

Address \_\_\_\_\_

Signature of Physician \_\_\_\_\_ Telephone \_\_\_\_\_

License No. \_\_\_\_\_ Date \_\_\_\_\_