



THE HEBREW UNIVERSITY OF JERUSALEM

ROTHBERG INTERNATIONAL SCHOOL



Medical History Form

Dear Applicant,

Thank you for applying to the Hebrew University of Jerusalem.

In order to be able to provide you with the appropriate support during your stay at Hebrew University of Jerusalem, please fill out the following health declaration that will help us identify your needs and prepare to meet them. This information will remain confidential.

Your health declaration is an essential part of the application for participation in study abroad programs at the Hebrew University. Please answer all question below, and contact your physician to complete the second part of this form.

Name of Applicant: _____ Social Security Number: _____

Please indicate the program to which you are applying: _____

Address: _____

E-mail Address: _____

Date of Birth: _____ Age: _____ Gender: _____

Please answer the following questions in detail:

1. Is there a medical condition of any kind that may affect your daily routine in any way?

☐ No.

☐ Yes. Please specify:

2. Are you currently undergoing medical treatment or taking medication regularly (including psychiatric medications)?

☐ No.

☐ Yes. Please specify the medication name and its purpose:

3. Have you ever been hospitalized or undergone any type of surgery?

☐ No.

☐ Yes. Please specify:

4. Do you have a history of psychiatric care?

☐ No.

☐ Yes. Please explain and provide dates:

5. Are you allergic to any type of food or medication?

☐ No

☐ Yes. Please specify:

6. Are you vaccinated against Covid-19?

- ☐ No.
☐ I intend to get vaccinated before my arrival.
☐ I intend to get vaccinated in Israel.
☐ I am not sure whether to get vaccinated.
☐ Yes.

7. Are you a recovered patient of Covid-19?

- ☐ No.
☐ Yes.

APPLICANT DECLARATION

I hereby certify that, to the best of my knowledge, this health declaration form is complete in all its details, and I fully realize that any condition, mental, or physical that I am found to have, originating prior to my arrival in Israel, and which is not described in full in this form or in any accompanying letter, will be due cause for my return to my country of origin, or treatment in Israel solely at my expense, and that the Program has neither responsibility nor liability arising out of such condition.

I will update the HUJI International staff if any change occurs during my stay in the program.

Date: _____ Signature: _____

To be answered by the applicant's physician

What is your evaluation of the applicant's general health and emotional stability (bearing in mind the various conditions imposed by a foreign study program: Permanent use of Medicines, lengthy absence from home, adjustment to a foreign culture, different living conditions, etc.)?

PLEASE VERIFY THAT ALL QUESTIONS HAVE BEEN ANSWERED BEFORE SIGNING BELOW

Physician Statement (signed and stamped):

I have examined the abovementioned applicant and consider him/her physically qualified to participate in study at the Hebrew University of Jerusalem.

Name of Physician (please type or print): _____

Address: _____ Signature of Physician: _____

Telephone: _____ License No.: _____

Date: _____

Please scan and upload this form to [your online application](#).