

Midreshet B'erot Bat Ayin Medical Form
(This information will be kept strictly confidential)

Full Name:

Name in English

Name in Hebrew

Medical Insurance Company & Contact Information:

Company Name

Policy Number

Address

Phone

Emergency Contact Numbers:

Name: _____ Relationship to Student: _____

Address: _____ Phone: _____

Emergency Contact In Israel (if different from above):

Name: _____ Relationship to Student: _____

Address: _____ Phone: _____

Do you suffer from any allergies (food or medication)? No Yes If yes please list: _____

Do you have any special dietary needs? No Yes
list: _____

Have you ever suffered from an eating disorder? No Yes Details and Dates: _____

Do you suffer from any illnesses? No Yes If yes, please explain: _____

Have you ever been hospitalized? No Yes If yes, please give details and dates: _____

Do you take medication? No Yes If yes, please list medications: _____

What are the most pressing psychological issues you are dealing with?

Have you ever consulted or been treated by a psychologist, social worker or counselor? No Yes
If yes, please explain including dates, situation, medications prescribed and place of treatment:

Do you smoke? If so, how much? _____

What has been the extent of your involvement with drugs or alcohol?

Is there anything else we should know about? _____

I certify that I have accurately indicated any medical and/or psychological problems that I have received treatment for in the past or that I am currently being treated for:

Signature

Date