Physician's Authorization

Student Name: ____

1. Vision: ______________________________ Hearing: ______________________
2. General Examination

	Normal	Deviation from Normal
Height	______	__________________
Weight	______	__________________
Heart	______	__________________
Lungs, Chest	______	__________________
Blood Pressure	______	__________________
Hemoglobin	______	__________________
Abdomen, Digestive Tract	______	__________________
Mouth, Throat	______	__________________
Skin	______	__________________
Spine	______	__________________
Feet	______	__________________
Nervous System	______	__________________
Allergies	______	__________________
Menstrual History	______	__________________

Other remarks:____
____

3. a) Is student presently receiving any medications? Is so, please attach statement of such medications with dosage and directions.
b) List any medication that the student has taken regularly at any point over the last three years.
____
____

4. Does the student have any history of an eating or dietary disorder, or currently manifest any signs of either? ( ) No ( ) Yes
Details: ____

5. Does the student have any physical limitations: ( ) NO ( ) YES
Details: ____

6. Date of last tetanus immunization: ____

I have examined the above named student and DO consider her physically and emotionally able to participate in your program in Israel.

Name of Physician (please print): ____
Address: ____ Phone: __________________________________
Date: ______________________ Signature: ____

To the best of my knowledge, all the above information is both accurate and complete.
Student Signature ____