March of the Living International

In Association With
Central Agencies of Jewish Education
Youth Movements and Organizations

YOUTH
Medical Data Form

Name of Applicant: ..... Email .....

Central Office
International March of The Living
2 West 45th Street, Suite 1500
New York, NY 10036
Tel: (212) 869-6800 Fax: (212) 869-6822
Email: motl@motlmail.org
Website: www.motl.org

RETURN TO
LOCAL AGENCY OR FEDERATION

PART 1 – FOR THE APPLICANT

1. This Medical Form must be filled out by a physician who is not related to you and has known you for at least 18 months. In addition, if you are under the care of a specialist, (i.e. cardiologist, neurologist, psychiatrist, psychologist, social worker, physical therapist, etc.) you must submit a written report from a specialist detailing your diagnosis, treatment, and prognosis. Failure to submit such a report can result in your expulsion from this program without any return of funds.
2. If you don't have a physician, contact your local agency for instructions.
3. If you will be taking prescription medication while on this program you must submit a written report giving full details of each medication. It is advisable to travel with a written generic prescription for each medication. You must also bring two complete sets of your medication with you.
4. If any changes take place in your medical or emotional condition within ten (10) days prior to departure of this program, you must immediately submit a full explanatory letter, signed by an appropriate, qualified medical or psychological professional, detailing your diagnosis, prognosis, and treatment. Failure to submit such a report may result in your expulsion from this program without any refund.
5. It is our intention to rely on this completed form and supplementary letters in determining your acceptance and participation in this program. Omissions or misstatements are at your risk and that of your physician(s) or therapist(s).
6. Should you be found to have any condition, mental or physical, that is not fully disclosed in this Medical Form or in an accompanying letter from an appropriate, qualified medical or psychological professional, then:
   (a) you may, at the sole and absolute discretion of the program, be returned to the USA at your own expense, or be treated in the country(ies) you are visiting, at your own expense, without monetary refund.
   (b) the leadership of this program and its sponsoring organizations are hereby released from all responsibility or liability of any kind whatsoever arising out of any aspect of your medical history and mental or physical condition.

PERSONAL HEALTH HISTORY

To be completed by the applicant. Fill in every answer. Do not leave any blank spaces.
When not applicable, write N/A. All information will be treated confidentially.

Name:.....

Birth Date: ..... Sex: ☐ Male ☐ Female Email .....

Home Address .....

.....
City State Zip

Medical Insurance (company): .....Company Policy No. ..... **[Submit copy of your insurance record/card]**

Family History:

Father's Name ..... ☐ Living ☐ Deceased Date of Death..... Cause of Death.....

Mother's Name..... ☐ Living ☐ Deceased Date of Death..... Cause of Death.....

Brother(s) ..... Sister(s) Number .....
☐ Living ☐ Deceased Cause of Death .....

Mark an "X" in the box next to the medical condition listed below that applies to your health history:

- ☐ Anemia
- ☐ Arthritis
- ☐ Asthma
- ☐ Bleeding Disorder
- ☐ Bronchitis
- ☐ Chemical Dependency
- ☐ Chicken Pox
- ☐ Convulsions/ Neurological Disorders
- ☐ Diabetes
- ☐ Eating Disorders
- ☐ Epilepsy
- ☐ Eye Ailments
- ☐ Fainting
- ☐ Frequent Colds
- ☐ German Measles
- ☐ GI/Stomach Problems
- ☐ Headaches
- ☐ Heart Ailments
- ☐ Kidney Ailments
- ☐ Measles
- ☐ Mononucleosis
- ☐ Motion sickness/Vertigo
- ☐ Mumps
- ☐ Orthopedic Fractures
- ☐ Pneumonia
- ☐ Poliomyelitis
- ☐ Psychological Problems
- ☐ Rheumatic Fever
- ☐ Scarlet Fever
- ☐ Sinusitis
- ☐ Sleep Walking
- ☐ Thyroid Condition
- ☐ Tuberculosis
- ☐ Tumors

Visual

- ☐ Eye Glasses
- ☐ Contact Lenses

Allergies:

- ☐ Hay Fever
- ☐ Insect Stings
- ☐ Penicillin
- ☐ Other .....

Female only:

- ☐ Regular Menstrual Cycle
- ☐ Menstrual Problems

1. If you checked any of the above please give all details including name(s), date(s) and address(es) of physicians and hospitals.

.....

.....

..... Date of Illness: .....

2. Do you have problems with eating? .....

.....

3. Have you undergone any operations or sustained any injuries? .....

If yes, give details, including dates, names and addresses of physicians and hospitals below. .....

.....

4. Are you taking any medication now? If so, please state name of medication, name of physician and condition being treated. .....

.....

.....

.....

5. Condition of health: .....

Date and nature of last illness.....

6. Describe any disabilities or restrictions. .....

If none, write "none." .....

7. Are you able to participate in a strenuous program? .....

.....

8. Have you ever been in any kind of physical therapy? If so, please indicate:

Person consulted..... Profession..... Date(s) of consultation.....

Reason .....

9. Have you ever been in any kind of psychological or social therapy? If so, please indicate:

Person consulted..... Profession..... Date(s) of consultation.....

Reason .....

10. Signature of applicant .....

Signature of parent if applicant is a teen participant.....

PART 2 - FOR THE PRIMARY CARE PHYSICIAN

NOTES TO THE EXAMINING PHYSICIAN

1. **Each March participant will face a new and strenuous environment, which will be physically and emotionally stressful. They will be living, eating and sleeping in a communal environment. They will be expected to participate in activities which will include long bus rides, walking long distances and other strenuous activities. They will visit places such as Auschwitz, Majdanek and Treblinka, where they will be emotionally affected. Therefore, it is essential that this medical report be as complete and precise as possible. Please bear in mind that the medical facilities available for participants will cover only acute illness and accidents. There are no facilities available within the framework of the March for the treatment of chronic disturbances.**

2. This form should only be completed by you if you have known the applicant for at least the last 18 months. In addition, if the applicant has been under the care of a specialist (i.e. cardiologist, neurologist, psychiatrist, psychologist, social worker, etc.) it is essential that the specialist submit a written report for use by the staff of the "March" to better service the applicant.

3. **If the applicant is required to continue receiving medication while participating in the program, he/she should be given a medical letter giving full details. Since medicine is not often available under the same trade name as in the United States, the full generic name should be given.**

4. It is our intention to rely on this completed form and supplementary letters in determining the final acceptance of the applicant into this program.

5. If you become aware of changes in the applicant's medical or psychological condition, please notify the central office of the March of The Living.

6. The information on this report and all supplementary material shall be held strictly confidential.

7. If you have any concern about the participation of the patient in this program, please contact the office of the **March of the Living** below.

LOCAL AGENCY OR FEDERATION

PHYSICAL EXAMINATION

(to be completed by a licensed physician)

	Normal	Abnormal	Describe Abnormality
HEIGHT	.....	.....	.....
WEIGHT	.....	.....	.....
BLOOD PRESSURE	.....	.....	.....
ALLERGIES	.....	.....	.....
DRUG ALLERGIES	.....	.....	.....
General Build	.....	.....	.....
Head	.....	.....	.....
Ears	.....	.....	.....
Eyes	.....	.....	.....
Nose	.....	.....	.....
Throat	.....	.....	.....
Neck	.....	.....	.....
Chest, lungs	.....	.....	.....
Heart	.....	.....	.....
Abdomen	.....	.....	.....
G.U. System	.....	.....	.....
Extremities	.....	.....	.....
Spine	.....	.....	.....
Skin, Lymphatics	.....	.....	.....
Nervous System	.....	.....	.....
Mental/Psychological State	.....	.....	.....

☐ significant past illnesses or emotional problems which might have a bearing on the participant's health while he/she is away.....

.....

☐ present physical or emotional problems.....

☐ medications - If so, list detailed prescription and exact instructions.....

.....

☐ dietary restrictions.....

☐ restrictions on physical activity.....

Required: Optional

☐ Tetanus Date ..... ☐ Influenza Date ..... ☐ Pneumococcus Date ....

My recommendations are as follows: .....

.....

.....

Name of Doctor .....

Address .....

Telephone # ( ) .....Date .....

Stamp & Signature Of Physician.....License# .....

PHYSICIAN'S STATEMENT

Name of Applicant: ..... Email .....

I have read the above medical form and thereafter have examined the above named participant and have recorded the results above which represent, to the best of my knowledge, all of the applicant's medical history and my findings. In my opinion, the applicant is

- ☐ capable of participating in the March of the Living program.
- ☐ incapable of participating in the March of the Living program (as outlined in the notes).

I have known the applicant for _____ years.

I understand that the leadership of the "March of the Living" and its representatives will rely on my report and findings.

* If you become aware of a change in the applicant's medical condition, please notify the:

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