AIM MEDICAL HISTORY FORM

75 N. Woodward Ave. #88294 Tallahassee, FL. 32313 USA | Phone: 1-800-4-AIM-PLAN | Fax : 305-359-5710 | Email: info@aim.co.il

STUDENT NAME: Casey Miller _____ BIRTHDATE: _____
Last name First Mid. Month Day Year

PASSPORT NO: _____ SOCIAL SECURITY NO. _____

FAMILY ADDRESS: _____
Address City State Zip Country

TELEPHONE: _____ _____ _____
Home Work Cell

PARENT EMAIL _____ STUDENT EMAIL _____

YESHIVA ATTENDING IN ISRAEL: _____

FAMILY PHYSICIAN: _____ TELEPHONE: _____

EMERGENCY CONTACT: _____ TELEPHONE: _____

IMMUNIZATION RECORD (CIRCLE NO.)

DPT 1 2 3 4 5 DATE OF LAST TETANUS IMMUN. _____

OPV 1 2 3 4 5 DATE OF LAST TETANUS IMMUN. _____

MEASLES (DATE) _____ HEPATITIS VACCINE: A _____ B _____

MUMPS (DATE) _____ MENININGOCOCCAL VACCINE _____

RUBELLA (DATE) _____ OTHER _____

PAST MEDICAL HISTORY

(Has student had any of the following? Check and describe details in space below.)

MEASLES _____ RUBELLA _____ MUMPS _____ CHICKEN POX _____ HEPATITIS _____

INFECTIOUS MONONUCLEOSIS _____ EATING DISORDER _____ ANOREXIA _____ BULEMIA _____

RECURRENT STREP THROAT _____ EYE PROBLEMS _____

RESPIRATORY DISORDERS _____ EAR PROBLEMS _____

INTESTINAL DISORDERS _____ SINUS PROBLEMS _____

URINARY TRACT DISORDERS _____ RHEUMATIC FEVER _____

NEUROLOGICAL DISORDERS _____ HEART DISEASE _____

PSYCHIATRIC DISORDERS _____ BLOOD DISORDERS _____

DERMATOLOGICAL DISORDERS _____ SKELETAL DISEASE _____

GYNECOLOGICAL DISORDERS _____ KIDNEY DISEASE _____

ALLERGIES (FOOD, MED, ETC.) _____ ASTHMA _____

ACNE _____

OTHER (explain below) _____

LIST BELOW ANY HOSPITALIZATION AND/OR SURGERY THE STUDENT HAS HAD

AGE / DATE: PROBLEM / OPERATION:

PHYSICAL EXAMINATION (DESCRIBE DETAILS IN SPACE BELOW)

HEIGHT 5'2" WEIGHT 143 PULSE _____ BLOOD PRESSURE _____

VISUAL ACUITY: **R** _____ **L** _____

	NORMAL	ABNORMAL		NORMAL	ABNORMAL
SKIN			ABDOMEN		
EARS			LIVER/SPLEEN		
HEARING			HERNIA		
TEETH			EXTREMITIES		
TONSILS			BACK		
GLANDS			GENITALIA		
HEART			MENSES		
LUNGS			OTHER		

MEDICATIONS (INCLUDE DOSAGE) _____

- HAS THE APPLICANT EVER BEEN DIAGNOSED, COUNSELED OR TREATED? (INCLUDING LEARNING ISSUES ,EATING DISORDERS ETC) IF YES, PLEASE SPECIFY _____
- HAS THE APPLICANT EVER RECEIVED PSYCHOLOGICAL/ PSYCHIATRIC TREATMENT? IF YES, PLEASE SPECIFY AND INCLUDE A LETTER FOR THE TREATING DOCTOR _____
- DO YOU HAVE RECOMMENDATIONS OR PRECAUTIONS WITH RESPECT TO DIET, ALLERGIES, HEALTH, PHYSICAL OR STRENUOUS ACTIVITIES? _____

PHYSICIAN'S STATEMENT

I HAVE EXAMINED _____ AND DO/DO NOT CONSIDER HIM/HER PHYSICALLY AND/OR EMOTIONALLY QUALIFIED TO PARTICIPATE IN AN OVERSEAS STUDY PROGRAM IN ISRAEL. HE/SHE CAN/CANNOT PARTICIPATE IN AN INTENSIVE WORKOUT PROGRAM. I CERTIFY THAT THE ABOVE STATEMENTS ARE TRUE AND COMPLETE TO THE BEST OF MY KNOWLEDGE.

PHYSICIAN'S SIGNATURE | PHONE NUM. | DATE

PARENTAL DECLARATION AND CONSENT FOR EMERGENCY MEDICAL TREATMENT

I HAVE REVIEWED THIS FORM AND DECLARE THAT TO THE BEST OF MY KNOWLEDGE THE INFORMATION HEREIN IS A FULL DISCLOSURE, ACCURATE AND TRUTHFUL. I HEREBY GIVE AUTHORITY AND CONSENT TO THE SCHOOL AND AIM TO OBTAIN NECESSARY MEDICAL TREATMENT AND/OR ACT ON BEHALF OF MY SON/DAUGHTER AND RELEASE HEALTH INFORMATION WITH UNDERSTANDING THE FAMILY WILL BE NOTIFIED AS SOON AS POSSIBLE.

SIGNATURE OF PARENT OR GUARDIAN | PHONE NUM. | DATE