NOTES TO THE EXAMINING PHYSICIAN

The new and strenuous cooking environment each participant will face may tax his/her physical and mental capabilities. It is therefore imperative, as a safeguard to the health of the participant that this report be as complete and precise as possible. This form should be filled out by a physician who has known the applicant for at least 18 months prior to the filling out of this form. In addition, any applicant who has been under the care of a specialist (for example, cardiologist, neurologist, psychiatrist, psychologist, social worker etc.) must submit a detailed report from that specialist giving a complete diagnosis, prognosis and evaluation.

If a participant is required to continue receiving medication while participating the program, he/she should have a medical letter giving full details. Since in many cases medicine is not available under the same trade name as in the country of origin, the full pharmacological name of all medicines and drugs used by the patient should be given. In any event, the participant should bring an extra supply of the medicine with him/her.

If any changes take place in the participant's condition following the examination and prior to the beginning of the program, the participant must submit, before departure, an explanatory medical letter, detailing diagnosis, prognosis and treatment. Failure to submit such a letter shall result in the expulsion of the applicant from the program with no refund.

FOR YOUR INFORMATION

1. ***Climate:*** Participants will be touring and working in a sub-tropical climate, with temperatures reaching 100 degrees Fahrenheit (35 degrees C). The climate is mostly dry with semi-arid conditions over a large part of the country.
2. ***Internship Environemnt:*** Participants are expected to be able to complete a 8-10 hour shift in a large kitchen, which includes being on their feet in a time-sensitive environment.
3. ***Social Environment:*** Most participants will be living in a communal environment. They will be sharing living quarters with others.
4. ***Medical Facilities:*** The physician should bear in mind that medical facilities are available for acute illnesses and accidents only and do not cover routine, chronic or any kind of pre-existing conditions.

VACCINATIONS

Please note that immunization against hepatitis B is compulsory for all participants. We also recommend vaccination against hepatitis A (with the 1440 ELU vaccine). Participants are also urged to have a booster of the inactivated polio vaccine if more than ten years have elapsed since the last dose and a booster of the tetanus/diphtheria vaccine if more than five years have elapsed since the last dose. Serotesting for mumps, measles and rubella with supplementary vaccinations as necessary are also recommended.

PLEASE NOTE:

The ORT Dan Gourmet, Dan Hotels and Study in Israel intend to rely on this completed form and supplementary letters in making the determination of acceptance of the participant to the program.

LIROM Global Education

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Omissions or mis-statements are at the risk of the applicant and his/her physician, psychiatrist, psychologist or social worker. The information on this form, and all supplementary reports on the physical and mental state of the applicant will be held by the ORT Dan Gourmet and Study in Israel (Lirom Global Education) and the Hotels' HR, as strictly confidential.
Should any participant, upon arrival in Israel, or during his/her stay, be found to be suffering from any condition, mental or physical, that is not fully disclosed in this medical form or accompanying letter then:

- He/she may, at the sole discretion of the program coordinator, be returned to his or her home country at his/her own expense (with no refund from the program)
- ORT Dan Gourmet, Dan Hotels and and Study in Israel are thereby released from responsibility or liability of any kind whatsoever arising from any aspect of such participants medical history and/or physical and mental condition.

D. PERSONAL HEALTH HISTORY
(to be completed by physician & participant)

Last Name:_____ First Name:_____
Date of Birth: _____ Date of Examination:_____
d / m / y d / m / y

Health History (answer "Y" for Yes or "N" for No)

ALLERGIES:	Asthma_____	Ear Infections_____	Headaches_____
Hay Fever_____	Bronchitis_____	Eating Disorders___	Heart Trouble_____
Insect Stings___	Chicken Pox_____	Epilepsy_____	Kidney Trouble____
Penicillin_____	Convulsions_____	Eye Trouble_____	Measles_____
Food Allergies: (list)	Diabetes_____	Fainting_____	Mononucleosis____
_____	Dizziness_____	Frequent Colds____	Mumps_____
_____	Drug Use_____	German Measles___	Pneumonia_____
_____	Poliomyelitis_____	Rheumatic Fever___	_
Other_____	Sleep Walking____	Thyroid Disorders__	Scarlet Fever_____
_____		Venereal Disease__	Tuberculosis_____

If Participant has asthma, please indicate: Mild _____ Medium_____ Severe_____
Please describe:_____

Dates of Immunization:
Tetanus:_____ Polio:_____ Hepatitis B (3):_____*

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***PLEASE ATTACH HEPATITIS B IMMUNIZATION RECORD TO APPLICATION. IF YOUR HEPATITIS B SHOTS ARE OVER 10 YEARS OLD YOU WILL NEED TO BE TESTED FOR IMMUNITY - PLEASE ATTACH THE RESULTS ALONG WITH A LETTER FROM THE DOCTOR CONFIRMING THAT THE RESULTS PROVE IMMUNITY. IF YOU ARE NOT IMMUNE, YOU WILL NEED TO HAVE A BOOSTER SHOT – PLEASE ATTACH A NOTE FROM YOUR DOCTOR FOR THE BOOSTER.**

TNE (TB) Test: Negative_____ Positive_____

- Please give all details concerning any allergy to which YES is answered above, including a description of reactions, details of medications required, names and addresses of physicians, hospitals and consulting specialist. _____
_____
_____

- Do you require carrying an Epipen? Yes____ No____
Please explain:_____
(For those with allergies needing Epinet Jr., please note that these are not readily available in Israel and an additional supply should be taken from home)

- Do you react to your allergy by ingestion or contact?_____

- Has the participant ever suffered any chronic recurring illness? If YES, give details and attach specialist's letter._____
_____

- Has the participant ever undergone any operations or sustained any serious injuries? If YES, give details including name and phone number of attending physician_____
_____
_____

- Is the participant taking any medication now? If YES, please specify the name of the medication(s) and condition being treated._____
_____

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ALL SECTIONS MUST BE FILLED OUT COMPLETELY AND WILL BE TREATED CONFIDENTIALLY

E. PHYSICAL EXAMINATION

(To be completed by a licensed physician)

	NORMAL	ABNORMAL	DESCRIBE ABNORMALITY
Head			
General Build			
Neck			
Ears			
Eyes			
Teeth			
Mouth, Throat			
Chest, Lungs			
Heart			
Vascular System-B.P.			
Abdomen & Viscera			
Hernia			
G.I. System			
G.U. System			
Upper Extremities			
Lower Extremities			
Spine			
Skin, Lymphatic			
Nervous System			

Weight_____ Height_____ Blood Type_____ Blood Pressure_____
Pulse_____ Respiration_____Hearing_____Vision_____
Any abnormal findings:_____

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F. PSYCHOLOGICAL

1. Is the participant currently involved in psychological therapy of any kind?
_____

If so: With whom? Psychiatrist ____ Psychologist ____ Counselor ____ Social Worker_____

2. Is there any history of psychological or psychiatric care? If YES, give dates:_____

3. Has the participant ever been advised to have counseling, psychotherapy or other psychiatric care?_____
_____

4. If yes has been answered to any of the above questions, please describe and explain
_____
_____

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PHYSICIAN'S STATEMENT

I have completed an examination of _____ whom I have known for _____years. The results I have recorded represent, to the best of my knowledge, all the participant's medical history and my findings on examination. I understand that the program organizers will rely on my report and findings. In my opinion the participant is physically, mentally and emotionally capable of participating in the program.

I recommend full physical activity: YES_____ NO _____ If NO, please explain:
_____

I recommend certain restrictions: YES_____ NO_____ If YES, please explain:
_____

I recommend a special diet: YES_____ NO_____If YES, please explain: _____
_____

Name of Physician (please print)_____
Address:_____
Telephone: (_____) _____ Date_____

Signature of Physician_____
License Number _____

PARTICIPANT'S STATEMENT

I hereby certify that, to the best of my knowledge, this medical 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 the beginning of the program, and which is not described in full in this form or in an 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 organizers have neither responsibility or liability arising out of such a condition.

All medication that I take regularly is at my own expense, and has been detailed on a medical insurance letter.

Name of participant_____Date_____

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