Physician's Report

Participant's Name: _____

Measurements: Height:_____Weight: _____ Blood Type: _____ Rh: _____

Immunization History:

Has the participant been protected against the following diseases? Please note year of most recent immunization.

Immunization	Yes	No	Date		Immunization	Yes	No	Date
Diphtheria					Polio (Salk)			
German Measles					Polio (Oral Sabin)			
Measles					Smallpox			
Mumps					Tetanus			
Hepatitis A					Whooping Cough			
Hepatitis B					Other:			
These immunizations are not required by Israel. Immunizations should be based on consultation with physician.								

Covid-19:

Has the participant tested positive for Covid-19 : _____ If , YES – on what date _____

Has the participant been vaccinated for Covid-19 : If , YES – which vaccine and on which dates :

Health Examination:

The participant is under the care of a physician and/or therapist for the following conditions: _____

Current treatment (include current medications): _____

Explanation of any reported loss of consciousness, convulsions or concussion: _____

Note to examining physician: The participant will be participating in an Israel Program. The main activities may include touring, hiking, biking, swimming, and physical exertion in the sun. The Israeli climate is dry and hot, especially during the summer months.

Recommendations and Restrictions while in Israel:

Physician's Health Statement:

I have known the participant for ___ years and have examined the above person within the last year. To the best of my knowledge the information included in this form is complete and correct. In my opinion, the above participant is **capable / incapable** (please circle one) of participating in this Israel program. I understand that Keshet and its representatives in Israel will rely on my above report and finding.

Licensed Physician's Name:_____Date of Examination:_____

Phone Number:_____Licensed Physician's Signature:_____