תנועת
השומר הצעיר
Hashomer Hatzair
World Movement

SHNAT HACHSHARA HEALTH HISTORY AND MEDICAL FORM

Name of participant _____

Name of Program your applying to: _____

Birthdate (dd/mm/yy) _____

Name of Mother: _____

Name of Father: _____

Address: _____

_____

Phone (H)_____ (W)_____ (C) _____

MEDICAL INSURANCE (if applicable)

Insurance company/ and plan number _____

(Photocopy enclosed)

Public Health Insurance (ex: OHIP) Policy Number (if applicable)

_____Version Code _____

(Photocopy enclosed)

EMERGENCY CONTACT <u>other than parents:</u>

Name _____

Address _____

Phone (H)_____ (W)_____ (C) _____

Relationship to participant_____

EMERGENCY CONTACT in ISRAEL

Name_____

Address_____

Phone_____

Relationship_____

Date_____ Signature_____

HASHOMER HATZAIR– SHNAT HACHSHARA HEALTH HISTORY AND MEDICAL FORM

Name of participant _____

Name of Parent/Guardian _____

Name of Physician _____ Telephone _____

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My signature on this form indicates that the information is correct and that I agree to the following:

- I, The participant is in good health and is physically able to participate in all shnat activities unless otherwise indicated. All medical problems or conditions requiring ongoing supervision or care have been adequately identified and described.

- I, the participant is in a stable mental health where he/she can live in a social surrounding far away from home.

- I, the participant has not been exposed to any infectious disease during the past four weeks. If he/she becomes exposed to any infectious disease between now and the time of departure for shnat I know that the Hashomer Hatzair Desk Director must be notified immediately.

- **I provide Hashomer Hatzair permission to both share information and receive information on my behalf from and with appropriate health care providers in order to obtain/provide necessary medical care.**

- I have clearly identified any and all medical concerns and conditions and provided information on this form about medications and/or strategies that can be used by staff for dealing with these.

Signature _____ Date _____

Parent's signature if under 18: _____

HASHOMER HATZAIR– SHNAT HACHSHARA HEALTH HISTORY AND MEDICAL FORM

Name: _____ Height: _____ Weight:_____

Immunization history:

Date of most recent booster of : Hepatitis B _____ Rubella _____

(dd/mm/yy) Diptheria _____ Measles (red) _____

Pertussis _____ Mumps _____

Polio _____ Meningitis _____

Date of last tetanus _____

Date of last TB test _____ ____negative _____positive ____chest x-ray

Past and Current Illnesses

If I currently have any of the following I am indicating this with a **C**

If I previously have had any of the following I am indicating this with a **P**

___ Chicken pox ____Frequent colds ____ADHD/ADD

____Measles (Red) ____Asthma ____Diabetes

____Measles (German) ____Eye trouble ____Thyroid disorders

____Mumps ____Severe Headaches ____ Stomachaches

____Scarlet fever ____ Fainting _____Bowel disorders

____Hepatitis ____Convulsions _____Constipation

____Rheumatic fever ____ Epilepsy _____Eating disorders

____Polio ____Heart condition _____Homesickness

____Mononucleosis	____Dizziness	_____Social-emotional
____Tuberculosis	____Bed wetting	_____Fears
____Whooping cough	____Kidney problems	____ Phobias
____Pneumonia	____Incontinence	_____Sleep walking
____Bronchitis	____Joint/muscle problems	_____Depression
____Sinusitis	____Hernia	_____Drug use
____Sexually transmitted disease	____Frequent ear infections	_____Smokes cigarettes

Details of these and/or other **ongoing illnesses** (please continue on the back or include additional pages as necessary):

_____
_____
_____
_____
_____
_____

Details of any **operations, serious injuries or hospitalization**. Please include dates, and details of any remaining effects:

_____
_____
_____
_____

MEDICAL DATA:

Major illnesses/allergies/concerns:

_____
_____
_____

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_____

Daily Medications (name, dosage, time of administration)

_____

_____

_____

_____

Allergies:

___Insect bites ___Penicillin ___Other drugs (please identify)_____

____Hay Fever ___ASA ___Animals (Please identify) _____

___Poison Ivy ____Sulpha ___Foods (Please identify)_____

*___Peanuts or other nut products

____Other (please identify) _____

I have an **Epipen ©** prescribed by a physician ___yes ____no

I can use it competently ____yes ____no

Detailed information of any allergies noted, including signs and symptoms of allergy and strategies used at home for dealing with this:

_____

_____

_____

_____

*I am clearly aware that Shnat Hachshara is **not** a nut-free environment ____yes

DIETARY:

Please check any that apply:

Red Meat Only ___

Vegetarian ___
Vegan ___

Lactose-Intolerant ___

Kosher ___

Other _____

I have identified any issues or concerns in relation to my eating:_____
_____

MEDICAL PHYSICIAN:

Please have your medical physician complete the following

Shnat Hachshara is a yearlong program which requires participants to live independently from their family in a foreign country, in a communal setting, participate positively in group activities, and participate in trips which require a moderate level of physical activity.

Although there will be older peer group leaders and access to emergency medical care there is no provision for ongoing medical or mental health care support for chronic conditions.

Are there any contraindications at this time for this person to participate in the program __yes ___no

Additional Comments:

_____
_____
_____

_____ _____

Physician Signature & Stamp Date

MENTAL HEALTH:

Currently or within the past year I have utilized mental health services: ___yes ____no

With this type of professional:

___Psychiatrist ___Psychologist ___Social worker ___Physician ___Other

I am receiving medication for this ___yes. ___no (If yes, I have provided all necessary information in appropriate sections of this form)

***If the participant is utilizing mental health services the following is to be completed by their mental health care professional:**

A letter from the mental health care professional must be attached that the participant is in stable condition to participate on shnat a long term program far away from home.

Shnat Hachshara is an 8 month program which requires participants to live independently from their family in a foreign country, in a communal setting, participate positively in group activities, and participate in trips which require a moderate level of physical activity.

Although there will be older peer group leaders and access to emergency medical care there is no provision for ongoing medical or mental health care support for chronic conditions.

Are there any contraindications at this time for this person to participate in the program __yes ___no