MEDICAL FORM This page is to be completed by student

All information will remain strictly confidential and will only be used by medical providers in case of medical necessity while the student is in the school. Students with pre-existing health conditions must have medical insurance/coverage or proof of ability to pay for any necessary medical treatment and medication. If there's a medical condition that affects one's attendance of classes, she will need to return home to care for her health. By signing this form you agree to pay for any costs associated with health care that may not be covered by your insurance should Machon Chana's staff determine you are in need of such.

Name of Student:		Date of Birth:				
In case of emergency contact: Name:		Relationship to you:				
Address:						
		Zip/ Postal code:				
Country:	Phone #:	Mobile Tel:				
1. Do you have any special dietary requirements?						
2. Do you now or have you ever suffered from an	eating disorder? Please pro	ovide details:				
3. Have you ever received psychological counseli	ing? If yes please provide de	etails:				
4. Do you suffer from any mental or emotional illn	esses? If yes please detail:					
5. Do you suffer from any allergies? If yes please	list:					
6. Do you suffer from asthma, eczema or hives?	If yes, please detail:					
7. Do you suffer from any of the following: Tuberculosis	☐ Yes such any other	tes				
9. Do you have any physical limitations? If yes pla	ease describe:					
10. Do you take any medication(s)? If yes please list	st name of medication(s) and	d reason for use:				
I1. Are you allergic to any medication(s)? If yes pleas	se indicate which medication	u(s):				
12. Is there anything else you feel we should know a	about your health?					
leaving out any information on this medical form is	cause for immediate expulsion is medical information that a	n is true and accurate to the best of my knowledge. Falsifying or purpose on from Machon Chana school and dorm, as well as cancellation of the a prospective student deems extremely confidential and does not wish to erview.				

Date

Applicant's Signature

MEDICAL REPORT

Machon Chana Women's Institute

Name							Date of Birth	
Address							Country	
Telephone Number				Mobile I	Phone Number			
Medical Exan	nination	to be com	pleted by Ph	ysician				
Weight			_					
Height			_					
Any recent finding	gs in any of	the following	areas:					
Eyes Ears Nose Mouth, Throat Skin	□ No □ No □ No □ No □ No	☐ Yes ☐ Yes ☐ Yes ☐ Yes ☐ Yes ☐ Yes		Heart Lungs Nervous sy Orthopedic Speech	□ No □ No stem □ No □ No □ No	☐ Yes☐ Yes☐ Yes☐ Yes☐ Yes☐ Yes☐ Yes☐ Yes		
If checked "yes" to	o any of the	e above, plea	se specify:					
Is the student curr	rently recei	ving any med	ications? If yes,	please attach statemer	nt of such medic	ations with dos	age and directions.	
List any medication	ons and rea	ason for medi	cation, the studen	ts has taken regularly	over the last thre	ee years:		
Does the student	have any μ	ohysical limita	tions? □ No 〔	☐ Yes If yes, please des	scribe:			
Date of last tetanu	ıs immuniza	ation:						
I have examined to	he above n	amed student	and consider her	physically and emotiona	ally able to partic	ipate in a full-tir	ne learning program.	
Name of Physician	n (please pi	rint clearly): _						
Address:								
Phone:								
Signature of Physi	ician					D	ate	
To the best of my	knowledge,	all the above	information is bot	h complete and accurat	e.			
Student Signature						Date		
Parent/Gaurdian S	Signature (It	f student is un	der 18 years of ag	je)		Date		