



6505 WILSHIRE BOULEVARD, SUITE 300  
LOS ANGELES, CA 90048  
PHONE: (323) 761-8605 ~ FAX: (323) 761-8640

**BJE March of the Living 2012**  
**MEDICAL DATA FORMS**

Please return completed forms to:

**BJE March of the Living – Attn: Monise Neumann**  
6505 Wilshire Blvd., Suite 300  
Los Angeles, CA 90048  
Tel: (323) 761-8613  
Fax: (323) 761-8640

**Instructions:**

1. Applicant please complete **Part 1 – Personal Health History** of this packet and return along with the **Applicant's Statement Re: Medical Data Form** immediately to the BJE-MOTL office in enclosed envelope.
2. **Part 2** of these medical forms must be completed by a physician who is not related to you and has known you for at least 18 months. In addition, if you are under the care of a specialist (i.e. cardiologist, neurologist, psychiatrist, psychologist, social worker, physical therapist, etc.), you must submit a written report from the specialist detailing your diagnosis, treatment, and prognosis. Failure to submit such a report can result in your removal from this program with only partial refund.
3. If you don't have a physician, contact the BJE for instructions.
4. If you will be taking prescription medication while on this program you must submit a written memo giving full details of each medication. It is advisable to travel with a written generic prescription for each medication. You must also bring two complete sets of your medication with you.
5. If any changes take place in your medical or emotional condition within ten (10) days prior to departure on this program, you must immediately submit a full explanatory letter, signed by an appropriate, qualified medical or psychological professional, detailing your diagnosis, prognosis, and treatment. Failure to submit such a report may result in your removal from this program without refund.
6. It is our intention to rely on this completed form and any supplementary letters in determining your acceptance and continuation in this program. Omissions or misstatements are at your risk and that of your physician(s) or therapist(s).
7. Should you be found to have any condition, mental or physical, that is not fully disclosed in this Medical Form or in an accompanying letter from an appropriate, qualified medical or psychological professional, then:
  - (a) you may, at the sole and absolute discretion of the program, be returned to the USA at your family's expense, or be treated in the country(ies) you are visiting, at your family's expense, and there shall be no refund of monies paid to this program; and
  - (b) the leadership of this program and its sponsoring organizations are hereby released from all responsibility or liability of any kind whatsoever arising out of any aspect of your medical history and mental or physical condition.

**Name of Applicant:** \_\_\_\_\_

## Part 1 – PERSONAL HEALTH HISTORY

*To be completed by the applicant. Fill in every answer. Do not leave spaces blank.  
When not applicable, write N/A. All information will be treated confidentially.*

Name: \_\_\_\_\_ Birthdate: \_\_\_\_\_ Sex:  Male  Female

Home Address: \_\_\_\_\_

Medical Insurance (company): \_\_\_\_\_ Company Policy No.: \_\_\_\_\_

### **Family History:**

Father's Name: \_\_\_\_\_  Living  Deceased [Date of Death: \_\_\_\_\_ Cause of Death: \_\_\_\_\_]

Mother's Name: \_\_\_\_\_  Living  Deceased [Date of Death: \_\_\_\_\_ Cause of Death: \_\_\_\_\_]

No. of Brothers: \_\_\_\_\_ No. of Sisters: \_\_\_\_\_  Living  Deceased [Date of Death: \_\_\_\_\_ Cause of Death: \_\_\_\_\_]

### **Mark an "X" in the box next to the medical condition listed below that applies to your health history:**

- |  |  |  |
|--|--|--|
| <input type="checkbox"/> Anemia                              | <input type="checkbox"/> Heart Ailments          | <b>Visual</b>                                    |
| <input type="checkbox"/> Arthritis                           | <input type="checkbox"/> Kidney Ailments         | <input type="checkbox"/> Eye Glasses             |
| <input type="checkbox"/> Asthma                              | <input type="checkbox"/> Measles                 | <input type="checkbox"/> Contact Lenses          |
| <input type="checkbox"/> Bleeding Disorder                   | <input type="checkbox"/> Mononucleosis           |  |
| <input type="checkbox"/> Bronchitis                          | <input type="checkbox"/> Motion sickness/Vertigo | <b>Allergies:</b>                                |
| <input type="checkbox"/> Chemical Dependency                 | <input type="checkbox"/> Mumps                   | <input type="checkbox"/> Hay Fever               |
| <input type="checkbox"/> Chicken Pox                         | <input type="checkbox"/> Orthopedic Fractures    | <input type="checkbox"/> Insect Stings           |
| <input type="checkbox"/> Convulsions/ Neurological Disorders | <input type="checkbox"/> Pneumonia               | <input type="checkbox"/> Penicillin              |
| <input type="checkbox"/> Diabetes                            | <input type="checkbox"/> Poliomyelitis           | <input type="checkbox"/> Other .....             |
| <input type="checkbox"/> Eating Disorders                    | <input type="checkbox"/> Psychological Problems  |  |
| <input type="checkbox"/> Epilepsy                            | <input type="checkbox"/> Rheumatic Fever         | <b>Female only:</b>                              |
| <input type="checkbox"/> Eye Ailments                        | <input type="checkbox"/> Scarlet Fever           | <input type="checkbox"/> Regular Menstrual Cycle |
| <input type="checkbox"/> Fainting                            | <input type="checkbox"/> Sinusitis               | <input type="checkbox"/> Menstrual Problems      |
| <input type="checkbox"/> Frequent Colds                      | <input type="checkbox"/> Sleep Walking           |  |
| <input type="checkbox"/> German Measles                      | <input type="checkbox"/> Thyroid Condition       |  |
| <input type="checkbox"/> GI/Stomach Problems                 | <input type="checkbox"/> Tuberculosis            |  |
| <input type="checkbox"/> Migraines                           | <input type="checkbox"/> Tumors                  |  |

over –

**Name of Applicant:**

1. If you checked any of the above, please give all details, including name(s), date(s), and address(es), of physicians and hospitals.

---

---

---

2. Do you have problems with eating? \_\_\_\_\_

---

3. Have you undergone any operations or sustained any injuries?  Yes  No

If yes, give details, including dates, names and addresses of physicians and hospitals: \_\_\_\_\_

---

4. Are you taking any medication(s) now? Is so, please state name of medication, name of physician and condition being treated:

---

---

5. Condition of health: \_\_\_\_\_

Date and nature of last illness: \_\_\_\_\_

6. Describe any disabilities or restrictions [if none, write "none"]: \_\_\_\_\_

7. Are you able to participate in a strenuous program? \_\_\_\_\_

8. Have you ever been in any kind of physical therapy? If so, please indicate:

Person consulted: \_\_\_\_\_ Profession: \_\_\_\_\_ Date(s) of consultation: \_\_\_\_\_

Reason: \_\_\_\_\_

9. Have you ever been in any kind of psychological or social therapy? If so, please indicate:

Person consulted: \_\_\_\_\_ Profession: \_\_\_\_\_ Date(s) of consultation: \_\_\_\_\_

Reason: \_\_\_\_\_

**10. Signature of applicant:** \_\_\_\_\_ **Date:** \_\_\_\_\_

**Signature of parent:** \_\_\_\_\_ **Date:** \_\_\_\_\_



6505 WILSHIRE BOULEVARD, SUITE 300  
LOS ANGELES, CA 90048  
PHONE: (323) 761-8605 ~ FAX: (323) 761-8640

**March of the Living 2012**  
**MEDICAL DATA FORMS – PART 2**

**PART 2 – TO BE COMPLETED BY THE PRIMARY CARE PHYSICIAN**

**NOTES TO THE EXAMINING PHYSICIAN**

1. Each March participant will face new and strenuous surroundings, which will be physically as well as emotionally stressful. They will be living, eating and sleeping in a communal environment. They will be expected to participate in activities which will include long bus rides, walking long distances and other strenuous activities. They will visit places such as Auschwitz, Majdanek and Treblinka, where they will be emotionally affected. Therefore, it is essential that this medical report be as complete and precise as possible. Please bear in mind that the medical facilities available for participants will cover only acute illness and accidents. There are no facilities available within the framework of the March for the treatment of chronic disturbances.
2. This form should only be completed by you if you have known the applicant for the last 18 months at least. In addition, if the applicant has been under the care of a specialist (i.e., cardiologist, neurologist, psychiatrist, psychologist, social worker, etc.) it is essential that the specialist submit a written report for use by the staff of the “March” to better serve the applicant.
3. If the applicant is required to continue taking medication while participating in the program, he/she should be given a medical letter giving full details. Since medicine is not often available under the same trade name as in the United States, the full generic name should be given.
4. It is our intention to rely on this completed form and supplementary letters in determining the final acceptance of the applicant into this program.
5. If you become aware of any change in the applicant’s medical or psychological condition, please notify the BJE (see address below).
6. The information on this form and all supplementary material on the physical, mental or psychological condition of the applicant shall be held strictly confidential.
7. If you have any concern about the participation of the patient in this program, please contact the local office of the BJE March of the Living.

**Please return completed forms to:**

**BJE March of the Living – Attn: Monise Neumann**  
**6505 Wilshire Blvd., Suite 300**  
**Los Angeles, CA 90048**  
**Tel: (323) 761-8613**  
**Fax: (323) 761-8640**

Name of Applicant: \_\_\_\_\_

**PHYSICAL EXAMINATION**

*(To be completed by a licensed physician.)*

	Normal	Abnormal	Describe Abnormality
HEIGHT	_____	_____	_____
WEIGHT	_____	_____	_____
BLOOD PRESSURE	_____	_____	_____
ALLERGIES	_____	_____	_____
DRUG ALLERGIES	_____	_____	_____
General Build	_____	_____	_____
Head	_____	_____	_____
Ears	_____	_____	_____
Eyes	_____	_____	_____
Nose	_____	_____	_____
Throat	_____	_____	_____
Neck	_____	_____	_____
Chest, Lungs	_____	_____	_____
Heart	_____	_____	_____
Abdomen	_____	_____	_____
G.I. System	_____	_____	_____
Extremities	_____	_____	_____
Spine	_____	_____	_____
Skin, Lymphatics	_____	_____	_____
Nervous System	_____	_____	_____
Mental/Psychological State	_____	_____	_____

Significant past illnesses or emotional problems which might have a bearing on the participant's health while he/she is away:

\_\_\_\_\_  
\_\_\_\_\_

Present physical or emotional problems: \_\_\_\_\_

\_\_\_\_\_

Dietary restrictions: \_\_\_\_\_

Restrictions on physical activity: \_\_\_\_\_

**VACCINATION INFORMATION:**

**REQUIRED**

Tetanus Date: \_\_\_\_\_

**OPTIONAL**

Influenza Date: \_\_\_\_\_

Pneumococcus Date: \_\_\_\_\_

My recommendations are as follows: \_\_\_\_\_

\_\_\_\_\_

Name of Doctor: \_\_\_\_\_

Address: \_\_\_\_\_

Telephone # ( ) \_\_\_\_\_ License #: \_\_\_\_\_

Stamp & Signature of Physician: \_\_\_\_\_ Date: \_\_\_\_\_

- over -

Name of Applicant:

**PHYSICIAN'S STATEMENT**

I have read the above medical form and thereafter have examined the above named participant and have recorded the results above, which represent to the best of my knowledge all the applicant's medical history and my findings. In my opinion, the applicant is

**capable** of participating in the March of the Living program.

**incapable** of participating in the March of the Living program (as outlined in the notes).

I have known the applicant for \_\_\_\_\_ years. To the best of my knowledge the information on these pages is correct.

I understand that the leadership of the "BJE March of the Living" and its representatives will rely on my report and findings.

**Physician's Name (please print):** \_\_\_\_\_

**Physician's Signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_

\*If you become aware of a change in the applicant's medical condition, please notify:

**BJE March of the Living**

Monise Neumann

6505 Wilshire Blvd., Suite 300

Los Angeles, CA 90048

(323) 761-8613 ~ [mneumann@bjela.org](mailto:mneumann@bjela.org)



6505 WILSHIRE BOULEVARD, SUITE 300  
LOS ANGELES, CA 90048  
PHONE: (323) 761-8605 ~ FAX: (323) 761-8640

BJE March of the Living 2012

**APPLICANT'S STATEMENT RE: MEDICAL DATA FORM**

**Please read the following statement. Make sure you sign and date it at the bottom, and return it to the BJE office with your personal health history**

**Applicant's Statement:**

*I have read the Notes to the Examining Physician on this Medical Data Form. I hereby certify that the Medical Data Form is complete in detail and fully realize that any condition, mental or physical, that is found to have originated prior to my departure, and which is not described in full on the form or in an accompanying letter submitted prior to departure, will be due cause for my return to the U.S., or treatment in the country I am visiting, at my or my family's expense, and that the March of the Living and its representatives have neither responsibility nor liability arising out of such condition. Furthermore, all medications that I take regularly are detailed in the Medical Data Form or accompanying letters.*

Applicant's Name (**please print**) \_\_\_\_\_

Applicant's Signature \_\_\_\_\_ Date \_\_\_\_\_

Parent/Guardian's Name (**please print**) \_\_\_\_\_ Relationship \_\_\_\_\_

Parent/Guardian's Signature \_\_\_\_\_ Date \_\_\_\_\_

I authorize the leadership of the March of the Living, both international and local, to obtain diagnosis/treatment for my child as it, in its sole and absolute discretion, deems necessary and advisable.

Name of Child \_\_\_\_\_

Parent Signature \_\_\_\_\_

Parent Signature \_\_\_\_\_

I authorize the leadership of the March of the Living, both international and local, to obtain diagnosis/treatment for my child as it, in its sole and absolute discretion, deems necessary and advisable.

Name of Child \_\_\_\_\_

Parent Signature \_\_\_\_\_

Parent Signature \_\_\_\_\_

I authorize the leadership of the March of the Living, both international and local, to obtain diagnosis/treatment for my child as it, in its sole and absolute discretion, deems necessary and advisable.

Name of Child \_\_\_\_\_

Parent Signature \_\_\_\_\_

Parent Signature \_\_\_\_\_

I authorize the leadership of the March of the Living, both international and local, to obtain diagnosis/treatment for my child as it, in its sole and absolute discretion, deems necessary and advisable.

Name of Child \_\_\_\_\_

Parent Signature \_\_\_\_\_

Parent Signature \_\_\_\_\_

I authorize the leadership of the March of the Living, both international and local, to obtain diagnosis/treatment for my child as it, in its sole and absolute discretion, deems necessary and advisable.

Name of Child \_\_\_\_\_

Parent Signature \_\_\_\_\_

Parent Signature \_\_\_\_\_

PLEASE SIGN THESE 5 "LABELS" AUTHORIZING OUR STAFF AND DOCTORS TO OBTAIN IMMEDIATE MEDICAL ATTENTION FOR YOUR TEEN (should the need arise).

THANK YOU!

