

Participant's Name \_\_\_\_\_

## INNOVATIONISRAEL HEALTH FORM

This form must be completed and signed by the participant's legal guardian. The information we ask you to provide is necessary in the event your child needs medical treatment. **This form will be returned to you if it is incomplete.** Please type or print

### PARTICIPANT INFORMATION

Participant's Name \_\_\_\_\_  
Permanent Address \_\_\_\_\_ Date of Birth \_\_\_\_\_ Sex \_\_\_\_  
City/State/Zip \_\_\_\_\_ Home Phone \_\_\_\_\_

### MEDICAL EMERGENCY CONTACT INFORMATION

Person to contact first:	Backup contact (relative or friend):
Name _____	Name _____
Relation _____	Relation _____
Daytime Phone _____	Daytime Phone _____
Evening Phone _____	Evening Phone _____

### INSURANCE POLICY INFORMATION

Provide the following information which is required by Health facilities in Israel to expedite treatment and to facilitate the billing process. Please send a copy of insurance card.

Policy Holder's (P.H.) Name \_\_\_\_\_ P.H.'s Date of Birth \_\_\_\_\_  
Address \_\_\_\_\_ Relation \_\_\_\_\_  
City/State/Zip \_\_\_\_\_ Occupation \_\_\_\_\_  
P.H.'s Employer \_\_\_\_\_  
Employer's Address \_\_\_\_\_  
Insurance Company \_\_\_\_\_  
Insurance Company's Address \_\_\_\_\_  
Policy # \_\_\_\_\_ Plan # \_\_\_\_\_

### MEDICAL TREATMENT CONSENT

I, the legal guardian of the above-named camper, authorize InnovationIsrael program staff to seek medical treatment for the student as health professionals see necessary. I consent to any x-ray, anesthetic, medical or surgical diagnosis or treatment and hospital care subsequently deemed necessary by a licensed health care provider during the participant's session. I understand that this authorization is given in advance of any specific diagnosis, treatment or hospital care, and that it is given to provide the program staff authority to seek medical treatment, and to provide a licensed health care provider the authority to administer this treatment as s/he judges necessary to the above-named child. I accept responsibility for payment of all services rendered; I authorize any medical facility which renders services to release medical information necessary for the processing of insurance claims; and I authorize the payment of insurance claims directly to the medical facility. I understand that whenever possible, the Program staff will make a good faith effort to contact me or the above-named person(s) before seeking treatment. If this is not possible, I understand that the Program staff will notify me or my designee as soon as possible of any and all diagnoses and treatments.

\_\_\_\_\_  
Legal Guardian's Signature

\_\_\_\_\_  
Print Name

\_\_\_\_\_  
Date

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**Directions:** Completion of this form by the student's physician is required before a student can participate. Please answer all questions. **Incomplete forms will be returned to you for the missing information.** Please type or print in black ink. Attach any specific recommendations from your physician to this form.

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**TO BE FILLED BY PHYSICIAN**

**DOES THE PARTICIPANT CURRENTLY HAVE ANY OF THE FOLLOWING?** (if yes, please describe)

Drug allergies: \_\_\_\_\_

Food allergies: \_\_\_\_\_

Allergies to insect bites: \_\_\_\_\_

Special dietary needs: \_\_\_\_\_

Asthma: \_\_\_\_\_

Frequent headaches: \_\_\_\_\_

Dizziness or seizures: \_\_\_\_\_

Emotional conditions (such as eating disorders, ADD, etc ) \_\_\_\_\_

**LIST:** Other health problems: \_\_\_\_\_

Limitations of Activities: \_\_\_\_\_

Medications the camper is currently taking: \_\_\_\_\_

**(Please note:** Our staff cannot administer any medications, prescription or non-prescription to participants. This includes over-the-counter medicines like Advil or Tylenol for minor headaches or pains. If the participant will need to take medications while attending our program, s/he must bring the medication to the program and assume responsibility for taking it as needed or indicated.)

Will your son/daughter require any specific treatment for a medical/emotional condition while participating in our program? If yes, please explain.                      yes \_\_\_\_\_no

**MEDICAL HISTORY**

**IMMUNIZATION DATES:**

Measles \_\_\_\_\_

Mumps \_\_\_\_\_

Rubella \_\_\_\_\_

*OR* MMR \_\_\_\_\_

Last Tetanus \_\_\_\_\_

(DPT, TT or TD)

Polio Series complete \_\_\_\_\_

Date of last medical check-up: \_\_\_\_\_

Hospitalizations in the past 5 years: Describe

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

**PHYSICIAN'S INFORMATION** (to be completed by physician) Please **PRINT** the following information:

Physician's Name: \_\_\_\_\_

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

City/State/Zip \_\_\_\_\_

Telephone \_\_\_\_\_

*I have examined the above named participant and found she/he to be able to participate in all activities of the InnovationIsrael 2007 Summer Program.*

\_\_\_\_\_  
Physician's Signature

\_\_\_\_\_  
Print Name

\_\_\_\_\_  
Date