

Birthright Israel: Israel Free Spirit

l am applyi	ng for a trip in the: Sur	nmer Season □	Winter Season □	Year	TAGLIT · J
MEDICAL FORM					BIRTHRIGHT
NAME OF APF	PLICANT (please print):		D.	ATE:	
DATE OF BIRT	r H: mm/dd/yyyy	TELEPHONE:			

Dear Doctor/Psychiatrist/Therapist,

Your patient has applied to be a participant on a Birthright Israel: Israel Free Spirit trip. They will be part of a group of 40 people for a period of 10 days. During that time, they must participate in a demanding itinerary including hours of walking/hiking each day, early mornings and late nights, rooming with strangers and participating in a daily average of 15 hours of programming.

As we have been made aware of the specific concerns/issues of this patient, we ask you that you sign this form as confirmation that, in your medical or professional opinion, this applicant will be able to fit in socially, physically and emotionally, being able to participate independently as part of the group, deal with early mornings and late nights resulting in lack of sleep without causing any negative impact on they or the other participants.

Please evaluate this applicant's condition in light of the following factors:

1) I believe that my patient/client will be able to live in a coin a dormitory or sharing living quarters with several other pe		•	
Please check the box if you agree or disagree	□Agree	□Disagree	
2) I believe that my patient/client will be able to participate include walking long distances, climbing, hiking, swimming ar			, which will
Please check the box if you agree or disagree	□Agree	□Disagree	
3) I believe that my patient/client is physically and em Birthright's demanding itinerary including hours of walking	•	•	•
nights. Please check the box if you agree or disag	ree □Agı	ree 🗆 Disagre	е
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Israel Free Spirit intends to rely on your confirmation in making determination of acceptance for or continuation of the applicant in the program. **Omissions or mis-statements may jeopardize the safety of the applicant and/or the other participants on the trip.** Israel Free Spirit may be in contact with you if deemed necessary.

The information on this form shall be held by Israel Free Spirit as strictly confidential.

I confirm that should any participant upon arrival in Israel, or during their stay, be found to be suffering from any condition, psychological or physical, that is not fully disclosed may, at the sole and absolute discretion of Israel Free Spirit or its representatives in Israel or in the US, be returned to his/her place of origin at the participant's own expense (and there shall be no refund on monies paid for the program). Israel Free Spirit is released from responsibility or liability whatsoever arising out of any aspect of this participant's medical history and psychological or physical condition.

It is imperative, as a safeguard to the health of the participant, that the information you provide be as complete and precise as possible. The applicant has given Israel Free Spirit permission to contact you with any concerns.



Birthright Israel: Israel Free Spirit

I am applying for a trip in the: Summer Season □

Winter	Season	
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MEDICAL FORM Please indicate if you are the applicant's: □Primary Care Physician **□Psychiatrist □Therapist** □Other: ____ What is the primary purpose of the applicant's consultations? How often does the applicant consult with you? How long has the applicant been your patient/client? _____ Is the applicant taking medications? Yes □ No □ FOR PRESCRIBING PHYSICIANS, ONLY If Yes, please indicate the medication(s) AND condition(s) for which you are approving this applicant's participation in our trip: Medication Treatment for Medication_____ Dosage _____ Treatment for _____ Dosage____ Medication Treatment for _____ If medication or dosage changes prior to the trip, the participant is responsible to inform Israel Free Spirit as soon as possible Please indicate if you're aware that the applicant has ever consulted a mental health professional (psychologist. psychiatrist, school psychologist, social worker, besides yourself) for any purpose? Additional Information: Name of Doctor, Psychiatrist, Therapist: (PLEASE PRINT) Phone: () Address/City: Signature of Doctor/Psychiatrist/Therapist Provincial License Number _____, give permission for Israel Free Spirit to contact Applicant Name (please print) this practitioner if it is felt any further information is required.

<u>IMPORTANT:</u> If you're confirmed on a trip this winter, then you are required to purchase the health/travel insurance via **CTAS**. Please go to http://www.israelfreespirit.com/pre-trip/health-travel insurance and purchase the insurance.

Applicant Signature _____ Date (mm/dd/yyyy): ____