Jewish Federation®
OF BROWARD COUNTY
ORLOFF DEPARTMENT OF JEWISH
EDUCATION AND ENGAGEMENT

MARCH OF THE LIVING – BROWARD COUNTY

NOTES TO THE PRIMARY CARE PHYSICIAN

(an individual who is not related to the applicant)

APPLICANT NAME (please print) ____

It is our intention to rely on this completed form and supplementary letters in determining the final acceptance of the applicant into our program. If you become aware of any changes in the applicant's medical or psychological condition, please notify the Broward County March of the Living (information below)

The information on this report and all supplementary material on the physical, mental or psychological condition of the applicant will be held strictly confidential

TRIP DESCRIPTION: Each March of the Living participant will face a new and strenuous environment, 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 that will include long bus rides, walking long distances and other strenuous activities
- They will visit death camps and other Holocaust related sites and they may 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. Although we will have medical personnel with us, there are no facilities available within the framework of the March of the Living for the treatment of chronic disturbances.

SPECIALIST CARE: In addition, if the applicant has been under the care of a specialist (ie. 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 of the Living to better take care of the applicant.**

MEDICATION: If the applicant is required to continue receiving medication while participating in the program, s/he should be given a medical letter providing full details. Since medication is rarely available under the same trade name as in the United States, the **full generic name** should be given

PHYSICIAN CONCERN OR CHANGES IN APPLICANT'S CONDITION:
If you have any concern about the participation of the applicant in this program or there have been changes to the physical, emotional or psychological conditions, please contact Rochelle Baltuch, Director of the **Broward County March of the Living** program at **954 660 2077 or** mol@jewishbroward.org Remember, all information will be held strictly confidential.

PHYSICAL EXAMINATION AND PHYSICIAN'S STATEMENT

to be completed by a licensed physician not related to applicant

APPLICANT NAME (please print) ____

	Normal	Abnormal	Describe Abnormality
Height	______	__________	__________________
Weight	______	__________	__________________
Blood Pressure	______	__________	__________________
General Build	______	__________	__________________
Head	______	__________	__________________
Ears	______	__________	__________________
Eyes	______	__________	__________________
Nose	______	__________	__________________
Throat	______	__________	__________________
Neck	______	__________	__________________
Chest, lungs	______	__________	__________________
Heart	______	__________	__________________
Abdomen	______	__________	__________________
Extremities	______	__________	__________________
Spine	______	__________	__________________
Skin, Lymphatics	______	__________	__________________
Nervous System	______	__________	__________________
Mental/Psychological State	______	__________	__________________

Significant PAST illnesses or emotional problems which might have a bearing on the participants health while s/he is away

____

Present physical or emotional problems____

Medications – if any, list all, prescription or over the counter, dosage and condition prescribed for _________________________

____

Allergies – food, drug or environmental____

Restrictions? Dietary _________________________________ Physical activity _______________________________________

VACCINES: DO NOT SUBMIT IMMUNIZATION RECORD

Tetanus: Date ___________________ Measles (or titer checked): Date __________

I have examined the individual named on this form and have recorded my results above, which represent to the best of my knowledge all the applicant's medical/emotional history and my findings. I will inform the Broward County March of the Living if I become aware of a change in the applicant's medical or emotional condition.

Name of Doctor: _________________________ Stamp or Signature of Physician ____

Full Address ____

Phone ____________ License # _____________________________ Date _____________________________

Broward County March of the Living 5890 S Pine Island Road Davie, Fl 33328
954 660 2077 mol@jewishbroward.org