



Jewish Federation<sup>®</sup>  
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 Galit Alboukrek, Director of the **Broward County March of the Living** program at **954 660 2077** or [mol@jewishbroward.org](mailto: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)** \_\_\_\_\_ **DOB** \_\_\_\_\_

	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 \_\_\_\_\_

Covid: Date \_\_\_\_\_ Date \_\_\_\_\_ Date \_\_\_\_\_

Covid Long Term Symptoms: \_\_\_\_\_

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 \_\_\_\_\_