PARTICIPANT: FIRST & LAST NAMES: _____

DALLAS MARCH of the LIVING

The Dallas group of the March of the Living joins the international March of the Living to spend one week in Poland studying the Holocaust by visiting concentration camps and sites of mass murder of the Jewish people during WW II. The following week the group travels to Israel. The goal of the program is to help inspire participants to fight indifference, racism and injustice by witnessing the atrocities of the Holocaust.

NOTES TO THE EXAMINING PHYSICIAN

1) TRIP DESCRIPTION:

This is a trip that is physically and emotionally stressful.

~ Students 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 you the doctor, consider your patient carefully and the medical report be as **complete** and **precise** as possible. We ask you to please consider chronic physical and emotional conditions that can affect the student.

The medical facilities available for participants will cover only acute illness and accidents. There are no facilities available within the framework of the March of the Living for the treatment of chronic conditions.

2) SPECIALIST CARE: ***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 service the applicant.** Please note the name of the specialist at the bottom of this form.

3) MEDICATION: If the applicant is required to continue receiving medication while participating in the program, please provide the full generic name of the medication. If possible please provide a prescription of the generic drug. *This is essential because medicine is rarely available under the same trade name as in the U.S.*

4) THIS REPORT: 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) CHANGES IN APPLICANT'S CONDITION: If you become aware of any change in the applicant's medical or psychological condition, please notify the Dallas March of the Living.

6) CONFIDENTIALITY STATEMENT: The information on this report form and all supplementary material on the physical, mental or psychological condition of the applicant shall be held strictly confidential.

7) PHYSICIAN CONCERN ABOUT PARTICIPATION: If you have any concern about the participation of the patient in this program, please contact the Dallas March of the Living **Phfine.moldallas@gmail.com**

Physician:

Please initial here_____

PARTICIPANT: FIRST & LAST NAMES: _____

PHYSICAL EXAMINATION

(To Be Completed by a Licensed Physician)

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

PARTICIPANT: FIRST & LAST NAMES: _____

Examining Physician; Please complete the following:

0 **Significant Past Illnesses** or emotional problems which might have a bearing on the participant's health while he/she is away:

.....

.....

0 **Present Physical or Emotional** problems:.

.....

0 **Medications** - If so, list detailed prescription and exact instructions..

.....

.....

0 **Dietary Restrictions**:..

.....

0 **Restrictions on Physical Activity**.....

0 **Allergies** and Treatment .....

.....

.....

0 **Physician Recommendations** are as follows: .....

.....

.....

Students Only (Copies of School Immunizations Records Must Accompany this Form for Students) :

0 **Tetanus** Date..... 0 **Influenza** Date 0 **Pneumococcal** Date .....

Name of Doctor:

Address:

Telephone #: (...) .....**Date**:.....

Stamp / Signature of Physician: **License**#: .....

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

0 capable of participating in the March of the Living program
0 incapable of participating in the March of the Living program (as outlined in the notes)

I have known the applicant for_____ . To the best of my knowledge the information, herein, is correct. I understand that the leadership of the "March of the Living" and its representatives rely on my report and findings.

Note to Physician:

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

Dallas March of the Living

Email: phfine.moldallas@gmail.com **Phone: 214-378-7011**