PARTICIPANT: FIRST & LAST NAMES: _____

MARCH of the LIVING – SOUTHERN REGION
FOR THE PRIMARY CARE PHYSICIAN

NOTES TO THE EXAMINING PHYSICIAN

1) **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 places such as Auschwitz, Majdanek and Treblinka, where they will 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. There are no facilities available within the framework of the March of the Living for the treatment of chronic disturbances.

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.** See contact info in numbers 5 and 7.

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

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 Southern Region of the March of the Living. 561-852-6013 or **mol@bocafed.org.**

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 Southern Region of the March of the Living. **561-852-6013** or **mol@bocafed.org.**

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:

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

……..……

❍ **Present Physical or Emotional** concerns:

……..……

❍ **Medications** - If so, list detailed prescription and exact instructions:

.....

.....

❍ **COVID-19 –** If patient has had COVID-19, please list date of illness and if any long-term symptoms remain:

……..

❍ **Dietary Restrictions**:……

❍ **Restrictions on Physical Activity:**.....

❍ **Allergies** and Treatment: .....

.....

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

.....

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

❍ **Tetanus** Date ..... ❍ **Influenza** Date ……..... ❍ **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***)….

❍ capable of participating in the March of the Living program
❍ 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:
March of the Living Southern Region 9901 Donna Klein Blvd. Boca Raton, Florida 33428
Email: mol@bocafed.org Phone: 561-852-6013