Miami's March of the Living

As a 21st Century Jewish teenager, I am an essential participant in the story of the Jewish people.

Name of Applicant: _____

MEDICAL FORM
(FOR THE PRIMARY CARE PHYSICIAN)

NOTES TO THE EXAMINING PHYSICIAN

1. Each March 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 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 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 for the treatment of chronic disturbances.

2. This form should only be completed by you if you have known the applicant for the last 18 months at least. 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.

3. If the applicant is required to continue receiving medication while participating in the program, he/she should be given a medical letter giving full details. Since medicine is not often available under the same trade name as in the United States, the full generic name should be given.

4. 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. If you become aware of any change in the applicant's medical or psychological condition, please notify our Miami's Leo Martin March of The Living office immediately.

6. 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. If you have any concern about the participation of the patient in this program, please contact our Miami's Leo Martin March of the Living office at:

Stephanie Goodman, MOTL Manager
miamimotl@caje-miami.org
Ph. 305-576-4030 x 143

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PHYSICAL EXAMINATION

(To be completed by a licensed physician)

	Normal	Abnormal	Describe Abnormality
HEIGHT	.....	.....	.....
WEIGHT	.....	.....	.....
BLOOD PRESSURE	.....	.....	.....
ALLERGIES	.....	.....	.....
DRUG ALLERGIES	.....	.....	.....
General Build	.....	.....	.....
Head	.....	.....	.....
Ears	.....	.....	.....
Eyes	.....	.....	.....
Nose	.....	.....	.....
Throat	.....	.....	.....
Neck	.....	.....	.....
Chest, lungs	.....	.....	.....
Heart	.....	.....	.....
Abdomen	.....	.....	.....
G.U. System	.....	.....	.....
Extremities	.....	.....	.....
Spine	.....	.....	.....
Skin, Lymphatic	.....	.....	.....
Nervous System	.....	.....	.....
Mental / Psychological State	.....	.....	.....

1.Significant past illnesses or emotional problems which might have a bearing on the participant's health while he/she is away _____

_____

2. Present physical or emotional problems _____

_____

3. Medications - If so, list detailed prescription and exact instructions _____

_____

4. Dietary restrictions _____

_____

5. Restrictions on physical activity _____

_____

6. Required: Optional

☐ Tetanus Date _____ ☐ Influenza Date_____ ☐ Pneumococcus Date _____

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7. Physician recommendations are as follows: _____

_____

_____

_____

_____

_____

Name of Doctor _____

Address _____

Telephone # ( ) _____ Date _____

Stamp & Signature of Physician _____ License# _____

****COVID-19 IMMUNIZATION CONFIRMATION (To be signed by parent/guardian)**

☐ I am confirming that my child is up to date with all vaccinations and/or immunizations required for attendance of this program including both Covid-19 vaccines.

Name of Covid-19 Vaccine _____

Date of last dose _____

Parent/Guardian Name _____ Signature _____

Date _____

PHYSICIAN'S STATEMENT

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

☐ Capable of participating in Miami's Leo Martin March of the Living program

☐ Incapable of participating in Miami's Leo Martin March of the Living program (as outlined in the notes)

I have known the applicant for_____ years. To the best of my knowledge, the information on these pages is correct.

I understand that the leadership of the "Miami Leo Martin March of the Living" and its representatives will rely on my report and findings.

Physician's Signature _____ Date _____

* If you become aware of a change in the applicant's medical condition, please notify Miami's Leo Martin March of the Living office at:

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APPLICANT'S STATEMENT

I agree to enroll in Miami's Leo Martin March of the Living Program, a highly intensive Jewish educational experience, to participate fully in all its aspects and to abide by its rules and regulations. I acknowledge the fact that usage or involvement with alcoholic beverages, drugs or narcotics, or any other type of anti-social behavior including failure to abide by its rules and regulations may be cause for my immediate dismissal from the program and my return to the United States at my own expense.

On the Medical Form enclosed, I have read the Notes to the Examining Physician. I hereby certify that the Medical Form is complete in detail and fully realize that any condition, mental or physical, that is found to have originated prior to my departure, and which is not described in full on this form or in an accompanying letter submitted prior to departure, will be due cause for my return or treatment in the country I am visiting at my expense and that the March of the Living and its representatives have neither responsibility nor liability arising out of such condition. Furthermore, all medication that I take regularly is detailed in the Medical Form or accompanying letters.

Applicant's Signature _____ Date _____

INSTRUCTIONS FOR SUBMITTING THE MEDICAL FORM

- Forms are due by January 2, 2023
- Upload a scanned copy of these documents to your portal by logging into your account (CLICK HERE) and clicking on your medical documents in your dashboard.