

ADULT



Medical Information Form

Name of applicant _____

MARCH OF THE LIVING is an international, educational program that brings individuals from all over the world to Poland on Holocaust Memorial Day, to march from Auschwitz to Birkenau, the largest concentration camp complex built during World War II, and then to Israel to observe Israel Memorial Day and Independence Day celebrations.

There are two parts to the Medical Information form, which need to be fully completed as part of your application for the program.

Part 1 – Medical history

- To be completed by the AMOTL applicant

Part 2 – Doctor's statement

- To be completed by your medical practitioner

Privacy and collection of information

The application forms for the AMOTL program include the questions relating to Personal, Sensitive and Health information.

Personal information is information that can identify you, such as your name, contact details (phone number and email addresses). Sensitive information includes details about your date of birth, affiliations and practices. Medical information includes both physical, mental and psychological conditions and treatment.

AMOTL collects this information to assist with processing your application and in tailoring the program and supporting educational material to suit the background and experiences of participants.

All personal and medical information obtained in the application process will be treated confidentially by AMOTL organisers and its medical advisors.

Prescription Medication

Participants should ensure they bring sufficient medication for the duration of the trip.

Participants should also obtain a prescription with the full generic name of the medication carried in

case of loss, since medicine is often not available under the same trade name in different countries.

Disclaimer

AMOTL relies on the information provided in application and medical history forms in determining a person's suitability for the program. Omissions or misstatements are at your risk and that of your physician(s) or therapist(s).

Should you be found to have any condition, mental or physical, that is not fully disclosed in this Medical Form, then you may, at the sole and absolute discretion of the program, be returned to Australia at your own expense, or be treated in the country(ies) you are visiting, at your own expense, and there shall be no refund of monies paid to the program

Consent (to be signed by Applicant)

I authorise my medical practitioner(s) to disclose/discuss my medical history with the AMOTL organisers.

List Names of Doctors below:

Dr Name: _____

Dr Name: _____

Dr Name: _____

Signature of Applicant:

Name (print): _____

Date: _____

PART ONE – MEDICAL HISTORY (To be filled in by Applicant)

Applicant Details:

Surname: First Name:

Date of Birth:/...../..... Male Female

Home Phone: Mobile:

Have you recently suffered from any of the following conditions? Circle: Yes or No

Asthma	Yes / No	Epilepsy	Yes / No
Diabetes	Yes / No	Heart Condition	Yes / No
Angina	Yes / No	Shortness of breath	Yes / No
Kidney disorder	Yes / No	Chronic bronchitis	Yes / No
Depression	Yes / No	Anxiety	Yes / No
Panic attacks	Yes / No	Neurological disorders	Yes / No
Back/Joint Problems	Yes / No	Psychological problems	Yes / No

Do you have difficulty in walking 4 km in 1 hour (steady walk) for up to 2 hours Yes / No

If YES, please state why? _____

Have you ever had any serious illnesses or fractures? Yes / No

If YES, please specify type of illness/fracture and approximate date.

Type: _____ Year (Approx.): _____

Type: _____ Year (Approx.): _____

Type: _____ Year (Approx.): _____

Type: _____ Year (Approx.): _____

Do you suffer from any medical conditions at present? Yes / No

If YES, please list? _____

Do you have any conditions that may affect your physical stamina? Yes / No

If YES, please indicate? _____

Do you have any physical restrictions or disabilities? Yes / No

If YES, please indicate? _____

Have you ever had treatment for a psychological disorder? Yes/No
(eg anxiety, depression, panic disorder, bipolar disorder, schizophrenia)

If YES, please indicate the condition and when this occurred?

Have you recently suffered a loss / death in the family? Yes / No

If YES, please provide details? _____

Have you ever had difficulties in a group setting? Yes / No

If YES, please indicate? _____

Do you suffer from any allergies to medications? Yes / No

If YES, please indicate? _____

Are you taking any medications? Yes/No

If YES, please list and state reason? (If extra space is needed, please use back of page)

Name of medication	Reason

PART TWO - DOCTOR'S STATEMENT

Applicant Name:

The March of the Living is a program in which thousands of Jewish participants from around the world gather in Poland to mark Holocaust Memorial Day where they will participate in a symbolic "March of the Living" and then travel to Israel for Israel's Independence Day.

The March is a group experience with the following requirements:

- Travel to Europe (prolonged sitting)
- Long bus rides
- Walking for up to 2 hours (with breaks) at a moderate pace
- Emotional and confronting experiences

Please note that there are no facilities available within the framework of the tour group for the treatment of chronic illness. Please provide adequate repeats of usual medications for the duration of the participant's journey.

Does the applicant have any active medical or psychiatric conditions? Yes / No

If YES, please indicate type, severity & state: _____

Does the applicant take regular medications? Yes / No

Details: _____

Are there any medical or psychiatric conditions that might impact on the participant's ability to participate? Yes / No

Comments or restrictions: _____

Is the applicant fit to participate in the March of the Living? Yes / No

Details: _____

Doctor's Name (stamp) Signature Date Phone

For queries please contact: Ms. Lena Fizman (March of the Living Administrator) on (03) 9528 1985 or LenaF@jhc.org.au