Hillel International

Immersive Experience Medical Clearance

Please PRINT and ensure both the applicant and clinician have completed this form. Completed forms can be emailed to israel@hillel.org with "Medical Clearance Form" in the subject line.

Applicant Name _____ **DOB** _____

Clinician Name _____ **Credential** _____

Practice Area _____ **Office** _____

Phone _____ **Email** _____

To the Clinician

Please review the student's medical history and discuss their upcoming travel plans and itinerary. By completing this form and signing below you confirm that to the best of your knowledge the student is sufficiently physically and mentally stable to participate fully in the entirety of the experience.

Travel to another country and/or in an immersive group setting can be physically and emotionally demanding. Please consult the client around any recommended medications, treatments, or accommodations, and develop a plan of care to support them in managing acute issues related to their condition(s), as needed. Eligibility will be confirmed once this form is reviewed by the Immersive Experiences team. This information will only be shared in service of the student's welfare related to the trip. Please reach out to Josh Hartman with any questions or concerns at jhartman@hillel.org.

Medical, Physical, and Psychiatric Needs

Date of Last Exam/Visit _____ **Frequency** _____

Additional comments or information may be supplied via a supplementary document.

Condition (Diagnosis, Disability, Allergy)	**Treatment (ie, Medication, Dietary Needs, Accomodations)**	**Additional Details (Acuity, Notes, Dosage, Frequency)**

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Participant Readiness

Immersive experiences may include the elements below. Please **initial** the relevant option. YES indicates the ability to manage the experience independently. SUPPORT indicates that accommodations may be required (clarify in the comments). NO indicates you do not believe they could be successful, or UNKNOWN if you are unable to assess.

The applicant is likely to be successful participating in:	**Yes**	**Support**	**No**	**Unknown**
Physically strenuous activities, including walks and hikes				
Long travel days, including early mornings and late nights				
Shared living quarters with other participants				
Organized group experiences, with limited personal time				
Unstructured free time (nights out, independent meals)				

COMMENTS

Medical Incident History

Please indicate if the patient has experienced any of the following by **initialing** in the proper column. If the answer is anything other than "NONE", please explain the status, prognosis and/or treatment in the comments.

Health Status	**None**	**Acute** (0-12 mo)	**History**	**Unknown**
Substance Abuse or Dependence (alcohol, drugs, illicit substances)				
Eating Disorder				
Hospitalizations (medical or psychiatric)				
A Manic or Psychotic Episode				
Suicidal Ideation				
Suicide Attempt				

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Self-injurious Behavior (ie, cutting or other non-suicidal self harm)				

COMMENTS

Medical Clinician Statement

It is my professional opinion that this student meets the physical/medical/psychological requirements to participate in a group immersive travel experience abroad as outlined above. I understand that Hillel International will rely on my reports and findings to determine the patient's eligibility in an immersive experience.

Clinician Name _____

Clinician Signature _____ Date _____

Applicant Statement

I certify that all responses made on this form are true and an accurate representation of my medical history and needs. I agree to notify the team of any relevant changes in my health in a timely way prior to the start of the program.

I acknowledge that failure to disclose my medical information may result in my immediate removal from the trip at my own expense, loss of any trip deposit or payments, return to my location of origin, or responsibility for payment of treatment. I understand that Hillel International has neither responsibility or liability arising out of such conditions.

I grant Hillel International and its trip partners permission to share information concerning my health status or condition with program representatives, my emergency contact, and with any medical provider necessary to treat me during my travel.

Applicant Name _____

Applicant Signature _____ Date _____