Achva
50 Eisenhower Drive, Suite 102
Paramus, NJ 07652
212-929-1525 ext. 181

PHYSICAL EXAMINATION REPORT INSTRUCTIONS

1. Achva is a teen travel program, which includes touring, physical activities and constant travel to a variety of locales. The strenuous environment each participant will face, taxes his/her physical and mental capabilities to the fullest. This report must be as complete and precise as possible, as a safeguard to the health and safety of the participant.

2. The participant will be touring throughout the program, with temperatures sometimes reaching well over 100 degrees.

3. The participant will be living in a communal environment. He/she will be sleeping in hotels, motels, and lodges, and sharing living quarters with other people, and eating in communal dining facilities.

4. The participant's activities will include hikes in remote areas far from any medical facilities and walking long distances, climbing, and other strenuous activities.

5. The physician should also bear in mind that medical facilities available for participants, will only cover acute illness and accidents. There are no facilities available within the program's framework for treatment of chronic disturbances. Medical care will, very often, be entrusted to fully trained para-medical personnel, although physicians will be utilized when necessary, as will local hospitals. In some cases, the patient may be transferred home for specialized medical treatment.

6. Further instructions to the physicians:

(a) This form should be completed by a physician who has known the applicant for at least 18 months. In addition, any applicant who has been under the care of a specialist (e.g. cardiologist, neurologist, psychologist, social worker, etc.) must submit a written report from such a specialist, giving complete diagnosis, prognosis and evaluation.

(b) If any applicant is required to continue therapy or treatment, or continue receiving medicines and drugs while under the auspices of the program, he/she should have a medical letter giving full details. Since, very often, medicine is not available under the same trade name as in the state of origin, the full pharmacological name of all medicines and drugs used by the patient should be given.

(c) If any changes take place in the applicant's condition before departure, the applicant must submit, before departure, a full, explanatory medical letter, detailing diagnosis, prognosis and treatment. Failure to submit such a letter shall result in expulsion of the applicant from his/her program, without a refund.

(Continued on the other side)

7. Achva intends to rely on this completed form and supplementary letters from his/her physician surgeon, psychiatrist, psychologist, or social worker in making determinations of acceptance for, or continuation of the applicant in the Achva program.

8. The information on this report form, and all supplementary letters and reports on the physical, mental, psychological condition of the applicant shall be held by Achva, and the staff of the Achva Program, as strictly confidential.

9. Should any participant, during the program, be found to be suffering from any condition, mental or physical, that is not fully disclosed in this medical form, or in an accompanying letter from a qualified medical or psychological professional,

    i. he/she may, at the sole and absolute discretion of Achva, or its representatives, be returned to his place of origin at the participant's own expense, and there shall be no refund of funds paid for the program, and

    ii. Achva and its representatives are thereby released of any liability of any kind whatever, arising out of any aspect of such participant's medical history, and mental or physical condition.

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Achva - Physical Examination Report

(to be completed by a licensed physician)

Name of Applicant: _____

	Normal	Abnormal	Describe Abnormality
Head	_____	_____	_____
Neck	_____	_____	_____
Ears	_____	_____	_____
Mouth, Throat	_____	_____	_____
Chest, Lungs	_____	_____	_____
Heart	_____	_____	_____
Vascular System - B.P.	_____	_____	_____
Abdomen and Viscera	_____	_____	_____
Hernia	_____	_____	_____
G.I. System	_____	_____	_____
G.U. System	_____	_____	_____
Upper Extremeties	_____	_____	_____
Lower Extremities	_____	_____	_____
Spine	_____	_____	_____
Skin, Lymphatics	_____	_____	_____
Nervous System	_____	_____	_____
Mental/ Psychological State	_____	_____	_____
Other	_____	_____	_____

_____Height _____ Weight _____

Urinalysis_____ Albumen _____ Sugar_____ Blood Type _____ RH _____

Medical History: Ever operated on? If yes, why and when?_____

_____

❑Past serious illnesses _____

❑Present physical ailments _____

❑Any restrictions on physical activities _____

❑Past emotional problems _____

❑Present emotional problems_____

❑Past or present problems with anorexia, bulimia or other eating disorders _____

❑**Medication:** List prescription medications currently being taken with exact instructions and likely side effects: _____

If sensitive to any medication, please list: _____

List allergies: (Include allergies to medication, food, other…)

_____

_____

-continued on the other side-

Has the patient received the following vaccinations:

__ MMR (1st Dose) Date _____

__ MMR (2nd Dose) Date _____

__ Rubella Date _____

__ DT (Most Recent Dose) Date _____

__ Polio Date _____

__ TBC Skin Test (Most Recent) Date _____

__ Other_____ Date _____

Achva Physical Examination Report

Name of Applicant: _____

Physician's Statement

I have read the notes to the examining physician and 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...

❑capable of participating in the Achva Summer Program (as outlined in the notes)

❑**not** capable of participating in the Achva Summer Program (as outlined in the notes)

I have known the applicant for_____years.

I understand that the leadership of the Achva Summer Program and its representatives will rely on my report and findings.

My recommendations are as follows:

_____

_____

_____

_____

_____

_____

Name: _____ Phone#:_____

Address:_____

Stamp and Signature of Physician:_____ License#: _____

If a change in the applicant's medical condition should occur, please notify us at:

Phone: 212-929-1525 ext. 181
Fax: 212 727-9526