# MARCH OF THE LIVING DOCTOR'S FORM

**PARTICIAPANT NAME: _____**

Dear Doctor,

My child is participating in March of the Living; a 2-week educational program taking place in the spring. The program consists of one (1) week in Poland and one (1) week in Israel in a group environment. MOL participants will face a new and **strenuous** environment which will be physically and emotionally stressful. They will visit places such as Nazi extermination camps where they will be emotionally affected. The program starts immediately upon arrival, with no rest after traveling. The program runs from early in the morning to late at night with very little "down-time" and minimal sleep. Participants will be subjected to long bus rides and walking long distances. Although there are volunteer physicians who travel together with the group, the volunteer physicians primarily deal with acute issues and have limited capacity to address complex medical issues. Medical facilities may be limited in some of the places visited.

**Given that this is a demanding experience, the program requests a doctor's indication that each teen is physically, emotionally, and psychologically ready and able to meet the program's demands.**

Thank you for providing an assessment of whether the teen under your care is prepared for the rigors of the program as described, and for indicating what if any limitations should be placed on the teen's participation.

**ALLERGIES:**

List all allergies below including the nature of the allergic reaction.
For food allergies indicate if participant can sit at the same table with the food, touch the food, if cross contamination is allowed and whether the allergy is airborne.

| Medication Allergies | Food Allergies | Environmental Allergies |
|---|---|---|
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**MEDICAL HISTORY:**

Provide details for any medical history that the participant has had including dates, treatment received and whether there are any ongoing treatments or issues related to these conditions for any medical history we should be aware of:

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**MEDICATIONS**

List all medications taken by the participant with the dose and frequency that the medication is taken. Include any occasional medications such as medications for asthma and allergies.

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Phone: 416-635-2883 ext.5367 | Email: wkarp@ujafed.org

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**It is recommended that no medication changes be made in the weeks leading up to MOL.**
Participants who take medications only during the school year (eg: medications for ADD/ADHD) are advised to continue these medications during MOL.
Check this box if the participant takes no medications ☐

**PSYCHOLOGICAL HISTORY**

1. Does the participant have a history of any psychological/psychiatric condition including but not limited to following: Anxiety, Depression, Phobias, Obsessive Compulsive Disorder, Oppositional defiant disorder, PTSD, Bipolar Disorder, Tourette Syndrome, Eating disorder, autism spectrum disorder and Substance use/abuse disorder. ☐ Yes ☐ No
2. Does the participant have a history of a learning disorder, ADD or ADHD? ☐ Yes ☐ No
3. What treatments has the participants received the above-mentioned conditions (check all that apply)?
   ☐ No treatment ever required.
   ☐ Currently taking medication
   ☐ Currently seeing a therapist/counsellor
   ☐ Previously took medication, but no longer required (date medication stopped:
   ☐ Previously saw a counsellor (date therapy ended: )
4. Please provide details for any YES answers, including the name and phone number of any therapist or psychiatrist seen:

**IMMUNIZATIONS: UP TO DATE IMMUNIZATIONS ARE MANDATORY IN ORDER TO PARTICIPATE ON MOL.**
Dates of immunizations may be available from your local public health department, the participants school or their physician's office.

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|---|---|
| Routine childhood immunizations up to date: | ☐ Yes ☐ No - Details if no |
| Date of last Meningitis vaccine: | |
| Date of last Tetanus vaccine | (A booster is required every 10 years) |

Based on the program description above and your knowledge of the participants medical history, including a recent physical examination, do you believe that the participant is physically, mentally and emotionally capable of participating in the program? ☐ Yes ☐ No

Please list any concerns or any additional information that you believe relevant

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**The provided information is complete to the best of my knowledge encompasses the participants full medical history.**

Signature: _____ Date: _____

Name of Physician: _____ Phone: _____