CANADIAN FRIENDS OF THE
HEBREW UNIVERSITY
OF JERUSALEM
האוניברסיטה העברית בירושלים

# Walk Israel with CFHU

Medical Form

Please send completed form back by
fax: 604-257-5144 or scan and email to: vanc@cfhu.org

First Name:_____Surname: _____

Address:_____Postcode: _____

Phone: _____ M_____F_____Birth Date: _____

Do you suffer from vertigo? Yes ( ) No ( ) _____

Do you experience any unusual chest pains or breathing problems while exercising? YES ( ) NO ( )
Comments:

_____

_____

_____

The purpose of this form is to assess the patient's physical capabilities to see if they are capable to train for and take part in trekking across the rocky, loose ground and mountains of the Israeli Negev Desert, about 50kms in total through steep desert terrain in 4 days.

**Medical Information to be completed by a Doctor**
**(This information will be kept strictly confidential)**

Name:_____Contact Details: _____

Does the patient have, or have they had any of the following? (Please indicate with a ✓or ✗)

( ) High Blood Pressure
( ) Pre-existing heart conditions or angina
( ) Stomach trouble or ulcers
( ) Concussion or head injury
( )Frequent Headaches or migraines
( ) Chronic or frequent cough
( ) Diabetes (type 1 or 2)
( ) Arthritis, rheumatism, chronic joint pain
( ) Knee, ankle or foot problems
( ) Anemia, hemophilia or any other blood disorders
( ) Skin disease
( ) Phobias
( ) Fainting Spells or Dizziness
( ) Heart stents or by-pass surgery
( ) Appendicitis
( ) Loss of consciousness
( ) Asthma or similar
( ) Malaria
( ) Epilepsy (type and last episode)
( ) Dislocation/s
( ) Back problems
( ) Ear, nose or throat disorder
( ) Depression
( ) Any other condition not listed

_____

_____

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Does the patient have any allergies of any kind? YES / NO

Specify:_____

If so, how severe is the allergy and what treatment does he usually require?

_____

_____

Has the patient had any recent surgery (including knee or joint operations)? YES / NO

Details:

_____

_____

_____

Has the patient ever been advised to have surgery that has not been carried out? YES / NO

Details:

_____

_____

_____

Is the patient currently taking any medication or carrying preventative medication? YES / NO

If so, what medication is required and please explain the procedure for administration:

_____

_____

_____

***Please ensure that your patient's heart and lungs are in good general health and that they have no existing musculo-skeletal problems that would prevent them from training for and completing this trek.**

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Doctor's Clearance:

I state that I have examined (patient name)_____for the purposes of assessing their ability to take part in training for, and hiking this physically demanding trek. In my opinion, there is no reason why they cannot participate in the trek and hike over 50km of steep terrain in 4 days.

Doctors Name: _____

Doctors Signature: _____

Date: _____

Doctors Stamp with name and phone number:

To be completed by participant:

I (full name)_____declare that all information provided is true and factual. I consent to the release of this medical information to the applicable staff of CFHU. I understand that this information will not be released to any other party without my prior consent. I consent to CFHU contacting my medical practitioner to discuss any relevant details.

Participant Name: _____

Participant Signature: _____

Date: _____