

## Health History Form

Note: Omitting information can place you at risk. Medical information will be kept confidential and shared only if necessary with relevant medical personnel.

Full Name \_\_\_\_\_ Phone # \_\_\_\_\_ E-mail Address \_\_\_\_\_

Date of Birth \_\_\_\_\_ Male \_\_\_ Female \_\_\_

### Medical Insurance Information

Please indicate the insurance information that the participant is covered by:

**Insurance Carrier:** \_\_\_\_\_

**Policy and Group #:** \_\_\_\_\_

\*\* Make sure that your insurance carrier covers **travelers / health insurance** internationally, if not you can purchase travels/health insurance through <http://www.travelprotectors.com/mission.shtml> choose Option 1: "**Cruise Tour and Travel**" package. Contact Myra Altschuler from Travel Protectors, LLC directly at 1-703-443-9055 / 1-877-515-9055 for more information.

### In an emergency, please notify:

Name \_\_\_\_\_ Phone # \_\_\_\_\_

Have you ever been hospitalized? If yes, for what reason and when?

\_\_\_\_\_  
\_\_\_\_\_

Have you ever suffered from: Heart Condition, Cancer, Cerebral Accidents, Nervous Disorders or any other health conditions?

\_\_\_\_\_  
\_\_\_\_\_

Have you ever required any operations for any condition or issue? If yes, please describe.

\_\_\_\_\_  
\_\_\_\_\_

At any time, have you ever had an injury as a result of an accident?

\_\_\_\_\_  
\_\_\_\_\_

Do you suffer from any form of disability?

\_\_\_\_\_  
\_\_\_\_\_

Any specific activities to be restricted?

\_\_\_\_\_  
\_\_\_\_\_

Do you suffer from any allergies?

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Any specific diet or restrictions?

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Please list any medical/emotional conditions you currently have or have had in the past:

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Are you currently taking any medications? \_\_\_\_\_

If so, which medications and for what conditions? \_\_\_\_\_

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Are you under any psychological treatment or counseling? Although we require information regarding treatment in counseling, this in no way means that you will not be accepted to the program. This information gives us the ability to deal with any situations that may arise on the program. Inaccurate information inevitably harms you, the participant. We require honest and factual information to appropriately determine your needs. Please explain.

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This health history is correct as far as I know. In the event that my emergency contact cannot be reached in an EMERGENCY, I hereby give permission to the physician selected by Israel Experience. Program to hospitalize, secure proper treatment for, and to order injection, anesthesia or surgery.

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Date

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**SEND ALL COMPLETED FORMS TO:**

Sephardic Educational Center (SEC)  
10808 Santa Monica Blvd.,  
Los Angeles, CA 90025  
Or Fax to 310.441.9561

Or can be scanned and emailed to [sbelilalti@secjerusalem.org](mailto:sbelilalti@secjerusalem.org)



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