

Athlete Name: _____ Delegation/Host: _____

2010 OFFICIAL JCC Maccabi Games Athlete Medical Form

(Form **MUST** be completed by a licensed physician and may not be substituted with any other form)

This examination must be performed within **ONE YEAR** of the 2010 JCC Maccabi Games. Examination for some other purpose within this period is acceptable however information must be transferred to this form and signed by the physician. Examination is for determining fitness to engage in strenuous activities. **If any change in athlete's medical condition occurs between time of medical visit and the 2010 JCC MACCABI GAMES, it is your responsibility to notify your DH and the Host Community**

CODE: [V=Satisfactory] [X=Not Satisfactory (explain)] [O =Not Examined]

Height:	Weight:	BP:	Heart:
Hct or Hgb Test:		Urinalysis:	
Eyes:	Glasses:	Lungs:	Extremities:
Ears:	Nose:	Throat:	Posture: (spine)
Skin:	Genitalia:	Hernia:	Abdomen:
Allergies:			

Do you carry an EPI Pen? YES NO Do you wear a Medic Alert Bracelet? YES NO

If you answered YES to any of the above, an accompanying letter is required giving details, medication and treatment together with Name, Address, and Phone Number of Specialist. _____

Details of Current Medication for Whatever Purpose, Strength, Frequency and Reason: _____

Please give details of any other medical conditions that you think would be important for us to know about i.e. Anorexia, Depression, etc. _____

Are there any other comments on family health or background that you think would be useful for us to know about i.e. Divorce, Recent Bereavement, Emotional Stress, etc. _____

If patient is consulting a Psychologist, Psychiatrist, or Social Worker please give dates, reason and physician's name, address and telephone number. _____

Previous Injury or Surgery (please specify with date): _____

Special Considerations: _____

Recommendations/Restrictions while at Games: _____

FEMALES ONLY:

Has this individual menstruated? YES NO If yes, is her menstrual history normal? _____

Have there been any changes in the specified individuals medical history or condition since his/her last physical? YES NO

If YES, please specify: _____

I have examined the person herein described and have reviewed the health history. It is my opinion that this Games participant is physically able to engage in Games activities, except as noted above.

Signature of Physician _____ Date: _____

Physician's Phone () _____

**** RETURN THIS FORM TO YOUR DELEGATION HEAD by: _____ ** date**