



Parent/Guardian: Once this form is completed please email a scanned copy or take a clear and legible picture and email it to talia@maccabigb.org. If the copy is not clear and legible, we will ask for another copy or the original via post so please retain the original for your records.

MEDICAL FORM

To be completed by the G.P.

GPs: Please read the accompanying notes about the Programme, then write in capitals and black ink. Return to the Parent/Guardian.

Full name of patient:

D.O.B of patient:

How long have you known the patient?

Current state of Patient's mental and physical health:

Medical history:

Please give a brief summary of the patient's medical history. Please provide information about any learning disability, mental health issue, emotional health, physical disability or medical condition and include details about the condition and capabilities of the Patient. For example, it is important to know if the patient has Autism, ADHD, self-harm, eating disorders, anxiety, depression, and/or history of substance abuse. Maccabi GB may contact you for more information which will, of course, be treated in confidence.

If the patient has pre-existing medical conditions, have they been stable for the past 6 months (change of medical treatment, worsening of condition, surgery or any other medical procedure)? **Yes** **No**

If **NO** please elaborate:



Is the patient currently under any Specialist or Therapist or is in the process of being referred to one for any type of physical or mental health condition? **Yes** **No**

If **Yes**, please give the name and the contact details of the professional:

Please specify the **condition** for which the Patient has been referred or treated by a Specialist/Therapist

Food intolerances / allergies / specific dietary issues:

Food	Allergy Y/N	Intolerance Y/N	EpiPen needed Y/N	Antihistamines Y/N	Other Treatment	Please describe reaction (include whether it's mild/moderate/severe)

Other Allergies (not food related):

Allergy	EpiPen needed Y/N	Antihistamines Y/N	Other Treatment	Please describe reaction (include whether it's mild/moderate/severe)

Please mark the activities the Patient can participate in:

Cycling Hiking Abseiling Water sports Swimming Diving Rafting Snorkeling Scuba diving

If one of the activities above is not approved, or approved in moderation/ or under certain limitations please specify:



Medication:

Is the Patient on any medication? (Including contraceptive pill)

Name of medication (generic name)	Strength of dosage	Frequency	Reason for medication

Immunisations:

Date of last anti-Tetanus: Date of last anti-MMR: Date of last anti-Polio:

Additional Comments about your patient:

GP's Statement:

I have known the Applicant for years, or months, and to the best of my knowledge of the patient and his/her medical reports, the details given to me by the patient and Parent/Guardian are complete and correct. In my opinion, at the time of signing this form, [Patient name] should be capable of fully participating in the Maccabiah Games as outlined in the notes.

I confirm that I have read and understood the accompanying notes explaining the full intensity of the Maccabiah Games.

GP's name (block capitals):

GPs Signature:

Surgery stamp:

Address (including postcode):

Telephone:

Email:

Date:

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