

Keshet Yehuda Integration Program

Application Form

Please submit the following with this application:

1. 2 letters of recommendation
2. signed medical form
3. \$100 non-refundable application fee

Mail to: **Integration Program**
 Mechinat Keshet Yehuda
 Moshav Keshet
 Ramat HaGolan 12410



Last name:		First name:		Hebrew name:	
Home Address:					
City:		State:		Zip code:	
				Country:	
Tel:		Cell phone:		Email:	
Date of birth:		Place of birth:		Passport #:	
Father's Name:		Hebrew Name:		Occupation:	
Home Address:					
Office / bus. Name and Address:					
Tel:		Fax:		Email:	
Mother's Name:		Hebrew Name:		Occupation:	
Home Address:					
Office / bus. Name and Address:					
Tel:		Fax:		Email:	

Siblings :**Name:****Age:****School / Occupation:**

1.

2.

3.

4.

List the schools you have attended:

	Name of School	Address	Years attended
Elementary School:			
Junior High:			
High School:			

SAT Scores:**Verbal:****Math:****Date taken:****Synagogue affiliation:****Rabbi's Name:****Youth Group Affiliation:****Extra curricular activities:****Camps attended (as camper/staff):**

Name	Dates	Role
1.		
2.		
3.		

Select your current level in:

	Excellent	Good	Fair	Poor
Hebrew עברית				
Tanach תנ"ך				
Gemara גמרא				

Please answer the following questions candidly:

1. What are your goals for the year?

Contacts in Israel:

Name:	Address:	Tel:	Relationship:
1.			
2.			
3.			



Health History

Your Health History is important and will aid in providing health care while you are enrolled. Carefully complete the enclosed health form and mail it to us as soon as possible. If you are being treated for any health condition, please ask that a summary be sent to us for inclusion in your health record.

All services are confidential. No medical information can be released to anyone, including your parents, without your written permission. For insurance purposes, information may be shared with your insurance company. **Please make a copy of this form and retain for your records.**

				Date	
Please Print or Type					
Student Last Name, First Name				Israeli's Only: Israeli ID#: Kupat Cholim:	
Address					
City		State		Zip	
Telephone	Cell Phone	Date of Birth	Age		

Emergency Contacts			Parents/persons to be contacted in case of an emergency. Please list two contacts.		
1. Name		Relationship		Home Phone	
Address				Indicate Cell or Work phone	
2. Name		Relationship		Home Phone	
Address				Indicate Cell or Work phone	

PRIMARY CARE PHYSICIAN	
Address	Phone
	Fax

Personal History

(PLEASE PRINT)

Name _____
Last First M. I.

HAVE YOU HAD? (circle choice)	Yes	NO	HAVE YOU HAD? (circle choice)	Yes	NO
Recurrent Headache			Epilepsy		
Eye Problem			Seizures		
Ear Problem			Dizziness		
Nose Problem			Fainting with exercise		
Throat Problem			Head Injury		
Thyroid Disorder			Concussion		
Heart Murmur			Bone Injuries		
Heart Disease			Joint Injuries		
Heart Palpitations			Stomach Problems		
High Blood Pressure			Intestinal Problems		
Low Blood Pressure			Diabetes		
Anemia			Eating Disorder		
Sickle Cell			ADD		
Bleeding Disorders: Hemophilia/Other			ADHD		
Hepatitis			Chicken Pox Vaccine		
Kidney Disorders			Chicken Pox Illness		
Bladder Disorders			Mononucleosis		
Pneumonia			Alcohol Abuse		
Bronchitis			Drug Abuse		
Tuberculosis					
Seasonal Allergies/Hay Fever			Mental Health Challenges: Specify below:		
Asthma			Emotional Problems-Specify below:		
Surgeries:					
Hospitalizations:					

Mental Health Challenges _____

Emotional Problems _____

By signing I am confirming that the Information I provided on this form is true.

Signed _____ Date: _____

Please Print Your Name: _____



Health History

Personal History

(PLEASE PRINT)

Name _____
Last First M. I.

List any medications that you are allergic to? _____

List any allergies to food, latex, herbal and over-the-counter medications? _____

List any other allergies? _____

List any medication you are currently taking? _____

Any other disease, illness, past surgeries, permanent disabilities or concerns?

Are you currently being treated by a health care professional? If yes, explain _____

By signing I am confirming that the Information I provided on this form is true.

Signed _____ **Date:** _____

Please Print Your Name: _____

Return completed forms to:
Mechinat Keshet Yehuda
Moshav Keshet, Ramat HaGolan
Israel, 12410
Fax: 972-4-696-3962