PHYSICIAN STATEMENT

TO BE COMPLETED BY THE PRIMARY CARE PHYSICIAN

NOTES TO THE EXAMINING PHYSICIAN

1. Each March participant will face new and strenuous surroundings, which will be physically as well as emotionally stressful. They will be living, eating and sleeping in a communal environment. They will be expected to participate in activities, which will include long bus rides, walking long distances and other strenuous activities. They will visit places such as Auschwitz, Majdanek and Treblinka, where they will be emotionally affected. Therefore, it is essential that this medical report be as complete and precise as possible. Please bear in mind that the medical facilities available for participants will cover only acute illness and accidents. There are no facilities available within the framework of the March for the treatment of chronic conditions.

2. You should only complete this form if you have known the applicant for at least the last 18 months. In addition, if the applicant has been under the care of a specialist (i.e., cardiologist, neurologist, psychiatrist, psychologist, social worker, etc.) it is essential that the specialist submit a written report for use by the staff of the "March" to better serve the applicant.

3. If the applicant is required to continue taking medication while participating in the program, please complete the medication chart provided on page 2 of this form. For additional space, please provide separate documentation. Since medicine is not often available under the same trade name as in the United States, the full generic name should be given.

4. If you become aware of any change in the applicant's medical or psychological condition, please notify March of the Living, Western Region (see address below).

5. The information on this form and all supplementary material on the physical, mental or psychological condition of the applicant shall be held strictly confidential.

6. If you have any concern about the participation of this applicant in this program, please contact Marcia Tatz Wollner, Director of March of the Living, Western Region at 858-395-3590 or Marcia @motlthewest.org.

***Return completed forms to:**

Marcia Tatz Wollner

Attn: March of the Living, Western Region

2771 Arnoldson Avenue

San Diego, CA 92122

***Completed forms can also be scanned and emailed to marcia@motlthewest.org.**

Name of Applicant:

PHYSICAL EXAMINATION

(To be completed by a licensed physician.)

	Normal	Abnormal	Describe Abnormality
HEIGHT			
WEIGHT			
BLOOD PRESSURE			
ALLERGIES			
DRUG ALLERGIES			
General Build			
Head			
Eyes Throat			
Chest, Lungs			
Heart			
G.I. System			
Endocrine			
Extremities Skin,			
Lymphatics			
Nervous System			
Mental/Psychological State			

Significant past illnesses or emotional problems, which may have a bearing on the participant's health while he/she is away:

Present physical or emotional problems:

Dietary restrictions:

Restrictions on physical activity:

VACCINATION INFORMATION:

REQUIRED
Tetanus Date*:
*Should contain Pertussis

REQUIRED
Influenza Date:

REQUIRED
COVID-19 Date:

REQUIRED
Pneumococcal Date:

Name of Applicant:

PHYSICAL EXAMINATION

(To be completed by a licensed physician.)

Medication (trade & generic name)	Dose/ Frequency	Routine or PRN	Condition Treated	Interactions	Side Effects

My recommendations are as follows:

_____

_____

I understand the physical and emotional intensity of the March of the Living Program. I have completed the above medical form and have examined the above named participant and have recorded the results above, which represent to the best of my knowledge all the applicant's medical history and my findings. In my opinion, the applicant is:

☐☐ **capable** of participating in the March of the Living program.

☐☐ **incapable** of participating in the March of the Living program (as outlined in the notes).

I have known the applicant for _ years. To the best of my knowledge the information on these pages is correct.

I understand that the leadership of the March of the Living, Western Region and its representatives will rely on my report and findings.

Name of Doctor: _

Address: _

Telephone #: _ **License #:** _

Stamp & Signature of Physician: _ **Date:** _

**If you become aware of a change in the applicant's medical condition, please notify Marcia Tatz Wollner at marcia@motlthewest.org or 858-395-3590.*