

Athlete/Artist Name: Jake Bernstein Delegation/Host City: Fl. Lauderdale



**2014 Official JCC Maccabi Games/ArtsFest  
Athlete/Artist Medical Form**

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

This examination must be performed within **ONE YEAR** of the 2014 JCC Maccabi Games/ArtsFest. 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 your child's medical condition occurs between the time of your medical visit and the 2014 JCC Maccabi Games and ArtsFest, it is your responsibility to notify your Delegation Head and the Host Community.**

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

Height: <u>6'7"</u>	Weight: <u>140 lb</u>	BP: <u>116/64</u>	Heart: <u>pulse 55</u>
Allergies: <u>φ</u>			

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: φ

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

Date of Last Tetanus Shot: 10/9/12

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. φ

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

Previous Injury or Surgery (please specify with date): ACL RECONSTRUCTION 10-9-12

Special Considerations: φ

Recommendations/Restrictions while at Games/ArtsFest: φ

**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/ArtsFest participant is physically able to engage in Games/ArtsFest activities, except as noted above.

Signature of Physician [Signature] Date: 5/30/14

Physician's Address 19801 Hampton Dr Boca Raton FL 33434

Physician's Phone (561) 977-2802

**\*\* RETURN THIS FORM TO YOUR DELEGATION HEAD by: 6/1/2014 date**

Athlete/Artist Name: Josh Bernstein Delegation/Host City: Fl. Lauderdale



**2014 Official JCC Maccabi Games/ArtsFest  
Athlete/Artist Medical Form**

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

This examination must be performed within **ONE YEAR** of the 2014 JCC Maccabi Games/ArtsFest. 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 your child's medical condition occurs between the time of your medical visit and the 2014 JCC Maccabi Games and ArtsFest, it is your responsibility to notify your Delegation Head and the Host Community.**

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

Height: <u>7'11"</u>	Weight: <u>210 lb</u>	BP: <u>119/66</u>	Heart: <u>rise 58</u>
Allergies: <u>none</u>			

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: φ

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

Date of Last Tetanus Shot: 6/8/10

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. φ

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

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

Special Considerations: φ

Recommendations/Restrictions while at Games/ArtsFest: φ

**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/ArtsFest participant is physically able to engage in Games/ArtsFest activities, except as noted above.

Signature of Physician [Signature] Date: 5/30/14

Physician's Address 19801 Hampton Dr. C-2, Boca Raton, FL 33434

Physician's Phone (so) 407-2862

**\*\* RETURN THIS FORM TO YOUR DELEGATION HEAD by: 6/1/2014 date**