Elaine & Norm Brodsky
DARKAYNU
Programs for Men and Women
אור"ת דרכינו

אור תורה סטון
OHR TORAH STONE

APPLICATION

ATTACH 2 ORIGINAL CURRENT PHOTOS

Applicant's Name _____
(please print) Last First Legal Name

Applicant's Home Address:

_____

City_____State_____Zip _____

_____
Country

Mailing Address (if different than above):

_____

Telephone: _____
Personal Home Cell

Cell Phone: _____
Mother Father

E-mail address _____
Personal Mother Father

Date of Birth: month/day/year_____Place of Birth:_____Citizenship_____

Social Security Number: _____Passport Number: _____

Country Issuing Passport: _____

Current School/Program _____

FATHER INFO:

_____
Last Name First Name Date of Birth Occupation Citizen

_____
Address (if different from applicant) Business Phone

MOTHER INFO:

_____
Last Name First Maiden Name Date of Birth

_____
Occupation Citizen

_____
Address (if different from applicant) Business Phone

Are parents: married, divorced, widowed or separated? _____

Applicant's name: _____
(please print) Last First

If you live with a guardian, please write his/her name and relationship to you:

_____

Siblings:			
Name	**Age**	**School/Occupation**	**Yeshiva attended in Israel (if applicable)**

Israeli Citizenship:

I have Israeli citizenship. YES____NO ____

My Teudat Zehut number is: _____

I was born in Israel YES____NO ____

One or both of my parents are Israeli citizens YES____NO ____

Education:

	Name	Location	Attended (from-to)
Elementary Schools			
Secondary Schools			

Jewish Schools (if not included above)

_____

Hebrew Skills:
Please rate yourself (circle or enter a number)
(1=none, 5 =fluent)

Read with vowels:____Read w/o vowels:_____Understand:_____Speak:____Write: _____
1 2 3 4 5 1 2 3 4 5 1 2 3 4 5 1 2 3 4 5 1 2 3 4 5

What Torah subjects have you studied? (Give Details)

_____
_____
_____
_____

Applicant's name: _____
(please print) Last First

Extra-Curricular Activities:

Describe your extracurricular activities in and out of school: List programs and organizations you have been involved with (use additional paper if necessary)

_____
_____
_____
_____
_____

What did you do the last three summers?

_____
_____

Previous visits to Israel (programs)

_____
_____

Work/Volunteer Experience:

_____
_____

FAMILY OR CLOSE FRIENDS IN ISRAEL (IF ANY):

Name_____Address _____

Telephone_____Relationship _____

Name_____Address _____

Telephone_____Relationship _____

I certify that, to the best of my knowledge, all the above information is true.

Signature of Applicant_____Date _____

Signature of Parent/Guardian_____Date _____

PERSONAL HEALTH HISTORY

Applicant's name _____
(please print) Last First

Have you or any members of your family suffered from:

	tuberculosis		epilepsy		emotional disturbances		heart disease
	asthma		diabetes		digestive tract diseases		other diseases

Details: _____

Please check appropriate answer below. If yes, give details Use separate sheet, if necessary.

3. Please list any hospitalizations and diagnosis? YES_____NO _____

Details and Dates: _____

4. Are you currently taking any medication? YES_____NO _____

Details and Dates: _____

5. Are you allergic to any medications? YES_____NO _____

If yes, indicate which medications:
_____

6. List any other allergies: _____

7. Have you ever received psychological counseling? YES_____NO _____

Details and Dates: _____

8. Do you have any physical limitations? YES_____NO _____

Details:_____

Contact in Israel to notify in case of an emergency:
1) _____

Number_____Cell_____Relationship _____

2) _____

Number_____Cell_____Relationship _____

This information will be kept strictly confidential

PERSONAL HEALTH HISTORY

Applicant's name _____
(please print) Last First

Has your child ever had: (please circle)

Concussion, or been knocked out?		YES		NO
Fainting?		YES		NO
Convulsions?		YES		NO
Head or neck injury?		YES		NO
Do you wear glasses, contacts, other?		YES		NO
Any broken bones?		YES		NO
Dislocation or other problems?		YES		NO
Serious foot problem?		YES		NO
Back injury or frequent backaches?		YES		NO
Ankle or knee injury problems?		YES		NO
Other joint problems?		YES		NO
Do you have a hernia?		YES		NO
Have you had diabetes?		YES		NO
Single illness for more than 10 days?		YES		NO
Easy bruising or bleeding tendency?		YES		NO
Anemia?		YES		NO
Asthma?		YES		NO
Bee sting allergy?		YES		NO
Penicillin allergy?		YES		NO
Hay fever allergy?		YES		NO
Other allergies?		YES		NO
Heart trouble or murmurs?		YES		NO
High blood pressure?		YES		NO
Chest pain or faintness with exercise?		YES		NO
Kidney problems?		YES		NO
German measles?		YES		NO
Measles?		YES		NO
Pneumonia?		YES		NO
Chicken Pox?		YES		NO
Sleep Walking?		YES		NO
Hearing loss or deafness?		YES		NO
Perforated eardrum or "tubes" in ears?		YES		NO
Concussion or been knocked out?		YES		NO
For Girls Only:		YES		NO
Any menstrual problems?		YES		NO
Do you miss school because of your period?		YES		NO

PERSONAL HEALTH HISTORY

Applicant's name _____
(please print) Last First

PLEASE PROVIDE AS MUCH DETAILED INFORMATION AS POSSIBLE THIS WILL MAXIMIZE OUR ABILITY TO WORK EFFECTIVELY WITH YOUR CHILD

1. Does your child have any specific medical problems?
Please specify. Include allergies to insect bites.

_____
_____
_____

2. Does your child have any special eating habits or allergies? Please specify.

_____
_____
_____

3. Does your child have any sleeping habits we should know about?

_____
_____
_____

4. Does your child have any unusual fears or anxiety?
Please specify. If so, how are they handled at home and at work or school?

_____
_____
_____

5. Are there any behavioral challenges (i.e temper) we should aware of? How do you deal with them?

_____
_____
_____

6. Please note other information we should aware of regarding your child. Remember, information that seems insignificant to you may be very important when working with your child

_____
_____
_____

EMERGENCY CONTACT FORM

Applicant's name_____Birth Date _____

Applicant's Home Address _____

City_____State_____Zip _____

Phone _____

In case of an emergency, please contact:

Name_____Relationship to participant _____

Phone_____ Cell _____

Name_____Relationship to participant _____

Phone_____Cell _____

Name_____Relationship to participant _____

Phone_____Cell _____

Physician to contact in case of an emergency:

Name_____Relationship to participant _____

Phone _____Cell _____

Address _____

City_____State_____Zip _____

Insurance Information:

Name of Cardholder_____Relationship to Participant _____

Insurance Company _____

ID # _____

Group # _____

Coverage includes: ☐ Prescription Drugs ☐ out-of-Country

Please be sure to include a copy of your child's insurance card with this

ESSAY

Applicant's name _____
(please print) Last First

Please write a short essay or provide a video presentation on the topic below.

WHAT I HOPE TO GAIN FROM MY YEAR AT DARKAYNU.

Please remember to include the application fee and two photographs. Please insure that your application and two letters of recommendation arrive prior to the deadline.

EMERGENCY MEDICAL FORM
(This information will be kept strictly confidential)

Name of Student: _____

Father's Name:_____Mother's Name: _____

Parents are married_____divorced_____separated_____widowed _____

Address:_____

Phone no,:_____Date of Birth: _____

Passport no. :_____Place of Birth_____

PERSON IN ISRAEL TO NOTIFY IN CASE OF EMERGENCY:

Name:_____Relationship to Student: _____

Address:_____Phone: _____

1. Height:_____Weight: _____

2. Have you or any member of your family suffered from: tuberculosis, epilepsy, emotional disturbances, heart diseases, asthma, diabetes, digestive tract diseases, other diseases. Please check appropriate answer below. If yes, give details, Use separate sheet if necessary.

(_) NO (_) YES Details:

_____
_____

3. Please list any hospitalizations and diagnosis: ( ) NO ( ) YES, Details and dates:
_____

4. Have you ever received psychological counseling ( ) NO ( ) YES, Details:
_____

5. Are you allergic to any medications: (_) NO (_) YES

If yes, indicate which medications:

_____

6. List any other allergies: _____

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MEDICAL EXAMINATION TO BE COMPLETED BY PHYSICIAN

Student : ____

Height:______________ Weight: ____________

1. Vision:____________________________Hearing: __________________________

2. General Examination	Normal	Deviation from Normal
Heart	______	_________________
Lungs, Chest	______	_________________
Blood Pressure	______	_________________
Hernia	______	_________________
Hemoglobin	______	_________________
Abdomen, Digestive Tract	______	_________________
Mouth, Throat	______	_________________
Skin	______	_________________
Spine	______	_________________
Feet	______	_________________
Nervous System	______	_________________
Allergies	______	_________________
Menstrual History	______	_________________

Other remarks: ____

3. a) Is the student currently receiving any medications? If so, please attach statement of such medications with dosage and directions.

b) List any medication that the student has taken regularly at any point over the last three years

____

____

4. Has the student manifested any signs of an eating/dietary disorder?
( ) NO ( ) YES Details:

____

5. Does the student have any physical limitations: ( ) NO ( ) YES

6. Date of last tetanus immunization : ____

I have examined the above named student and DO consider him/her physically and emotionally able to participate in your program in Israel

Name of Physician (please print): ____
Address:____
Date:_______________________Signature: ________________________
- -

To the best of my knowledge all the above information is both accurate and complete
Student Signature ____

Applicant's name _____
(please print) Last First

Prescription / Non prescription Medications

If your child is not on any prescription medications please go straight to the next page- Part B.

A. Prescription Medication

Please fill out one of these forms for EACH medication. You may use the back of the form if more room is needed.

Please provide us with as much information as possible pertaining to your child's medications as it can be a direct effect on the success of your child in the program.

1 a. What is the name and dosage of the medication you child is currently taking?

_____

b. How often? What time of day does your child take this medication _____

c. Does it say the same thing on the bottle? If no, please explain: YES____NO ____

_____

d. What is the medication for (what is it supposed to do)?

_____
_____

e. Who prescribed the medication? _____

f. How long has your child been on the medication for? _____

g. Does the medication interact with other medications or something else?

_____

h. Does the medication have any side effects that your child experiences?

_____

2.a. How does your child take the medication? _____

b. Is it taken independently? Or is a reminder needed?_____

c. Has the medication ever purposely not been taken_____

3. What is the procedure if a dose is missed? _____

4. What is your plan for filling the medication during your child's year in Israel?

(Are you sending replacement, are we filling the prescription- does it have refills on the bottle or are you sending a prescription?) _____

Applicant's name _____
(please print) Last First

B. Non- prescription medications

The better prepared we are even for the 'little' things, the more we can be of assistance to your child throughout her year and help her gain the utmost from all of her experiences.

1. Does your child get sick often?
Headaches, stomach aches, menstrual cramps, colds, coughs, or other…

_____

2. What do you suggest your child should do when he/she is not feeling well?

_____

3. What medications does your child take for the above listed ailments?

_____

4. Do you give your child aspirin, Tylenol, Advil? Which seems to have the best effect?

_____

5. Can your child swallow pills, or if not how does he/she take medication?

_____

For Girls Only:

6. What happens when your daughter has her period? Does she need medication?

Mood? PMS ? Cleanliness? Etc.

_____
_____
_____

7. Other information you think we should know:

_____
_____
_____