Machon L'Yahadus
Winter Program

בס"ד

School: 825 Eastern Parkway, Brooklyn, NY 11213
Dorm: 1367 President Street, Brooklyn, NY 11213
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*Remember to send a recent photo

APPLICATION FOR ADMISSION

Personal Background

Application Date Month ___ / Day ___ / 2016 Year

Last Name_____ First Name(s)_____ Hebrew Name _____

Current Mailing Address_____ Phone # (____)_____

City_____ State_____ Zip/Postal Code_____ Mobile Tel. (____)_____

E-Mail _____ Country of Citizenship _____ Social Security # _____

Age _____ Date of Birth Month ___ / Day ___ / 2016 Year Place of Birth _____ City State/Province Country

Marital Status: ○ single ○ married ○ divorced ○ separated ○ widowed Maiden Name: _____

Permanent Address Name & Relation living here: _____ Address _____

City _____ State _____ Zip/Postal Code _____ Phone # ( ) _____

Employer Name _____ Occupation _____ Phone ( ) _____

Father/Legal Guardian Name_____ Hebrew Name _____ Email

Address _____ Phone ( ) _____

City _____ State _____ Zip/Postal Code _____ Mobile ( )_____

Mother' s Name _____ Hebrew Name _____ Email

Address _____ Phone ( ) _____

City _____ State _____ Zip/Postal Code _____ Mobile ( ) _____

Was your mother born Jewish? ○ Yes ○ No If "no" please include a copy of your mother's or your conversion papers

In case of emergency contact: Name_____ Relationship _____ Phone ( ) _____

Addr. _____ City _____ State _____ Zip/Postal Code _____ Mobile ( ) _____

MEDICAL FORM
This page is to be completed by student

All information will remain strictly confidential and will only be used by medical providers in case of medical necessity while the student is in the school. Students with pre-existing health conditions must have medical insurance/coverage or proof of ability to pay for any necessary medical treatment and medication. By signing this form you agree to pay for any costs associated with health care that may not be covered by our insurance should staff of Machon L'Yahadus determine you are in need of such.

_____ _____
Name of Student **Date of Birth**

In case of emergency contact:

Name: _____ **Relationship to you:** _____

Address: _____

City: _____ **State:** _____ **Zip/Postal code:** _____

Country: _____ **Phone #:** _____ **Mobile Tel:** _____

1, Do you have any special dietary requirements?

_____

2. Do you now or have you ever suffered from an eating disorder? Please provide details:

_____

3. Have you every received psychological counseling? If yes please provide details:

_____

4. Do you suffer from any mental or emotional illnesses? If yes please detail:

_____

5. Do you suffer from any allergies? If yes please list:

_____

6. Do you suffer from asthma, eczema or hives? If yes, please detail:

_____

7. Do you suffer from any of the following?

Tuberculosis	**☐ No**	**☐ Yes**	**Diabetes**	**☐No**	**☐Yes**
Epilepsy	**☐ No**	**☐ Yes**	**Digestive tract diseases**	**☐No**	**☐Yes**
Heart diseases	**☐ No**	**☐ Yes**	**such as chronic constipation or diarrhea**		
Respiratory illnesses	**☐ No**	**☐ Yes**	**Any other significant illness**	**☐No**	**☐Yes**

8. Please list any hospitalizations and surgeries you have undergone:

_____

9. Do you have any physical limitations? If so please describe:
_____
10. Do you take any medication(s)? If yes please indicate which medication(s) and reason for use
_____
11. Are you allergic to any medication If yes please list name of medication(s):
_____
12. Is there anything else you feel we should know about your health?

_____

I affirm that all information contained in this application is true and accurate to the best of my knowledge. Falsifying or purposely leaving out any information on this medical form is cause for immediate expulsion from the Machon L'Yahadus Winter Program. If there is medical information that a prospective student deems extremely confidential and does not wish to write on this form, it can be discussed orally with Rabbi Shloma Majeski or Mrs. Yehudis Cohen upon submission of the application.

_____
Applicant's Signature **Date**