March of the Living International

In Association With
Central Agencies of Jewish Education
Youth Movements and Organizations

YOUTH Application

RETURN TO
LOCAL AGENCY OR FEDERATION

Please return this completed form to Our New York/New Jersey Regional Office
1 Eventide Court
Morris Plains, NJ 07950

Please email a nice headshot photo to MOTLJDKatz@gmail.com. It will be used for our Photo IDs.

Thank you

NAME OF APPLICANT

.....

EMAIL

.....

Central Office
International March of The Living
2 West 45th Street, Suite 1500
New York, NY 10036
Tel: (212) 869-6800 Fax: (212) 869-6822
Email: motl@motlmail.org Website: www.motl.org

INSTRUCTIONS TO APPLICANT

(Please read carefully before completing. Type or print legibly in pen.)

1. Answer all questions on this Application Form. Please type or print clearly. Answer all questions fully. If you wish to give additional information, attach an extra sheet. Be sure to attach six (6) passport type photos of yourself where indicated above.
2. Include a $400 refundable deposit made out to **March of the Living**. Write your name on the bottom of the check. No application will be considered without this deposit. **There will be no refund after January 31.**
3. **The medical form must be completed by you and your physician. The form must be signed by the physician.**
4. Have the enclosed Letter of Recommendation completed by your teacher, principal, Rabbi, guidance counselor or youth advisor. The Letter must be returned directly to the local agency through which you are applying (see above address). Recommendations from friends or family members are not acceptable.
5. Complete an essay on the form provided (on page 6), detailing why you want to go on the March of the Living.
6. **No application will be considered for approval without the essay, Letter of Recommendation, signed Medical Form, health insurance information and deposit.** Send all materials to the local agency through which you are applying [see address above].
7. A personal interview will be required locally prior to your being accepted into the program. Upon receipt of your application you will receive notification for that interview. Final acceptance is subject to the approval of the National Office. You will then be notified.
8. Retain copies of your completed application, essay and medical forms in the event that the originals are lost.
9. We recommend that you purchase trip cancellation insurance.

Name of Applicant: ..... Email .....

PERSONAL DATA

Name as Appears on Passport .....
Last First Middle Hebrew Name

Home Address .....
Street City State Zip

Family Phone # ( ) ..... Cellular # ( ) .....

Name you prefer to be called .....Date of Birth .....Age ..... Sex: ☐ Male ☐ Female

Health Insurance Coverage: Company.....Policy # .....

Country of Citizenship..... Country of Residence ..... Did your parents ever hold Israeli Citizenship? .....

Passport you travel with: Country.....Passport # .....Expiration Date.....

Citizen of Israel Yes ☐ No ☐ Israeli Passport # ..... Expiration Date:..... Pator?.....

FAMILY BACKGROUND

◆ **Name of Father** ..... Living ☐ Deceased ☐ Occupation:.....

Employer's Name..... Address..... Position.....

Home Address .....
Street City State Zip

Home Telephone # ( ) ..... Business Tel # ( ) .....Citizenship.....

Business Address .....
Street City State Zip

◆ **Name of Mother** ..... Living ☐ Deceased ☐ Occupation:.....

Employer's Name..... Address..... Position.....

Home Address .....
City State Zip

Home Telephone # ( ) ..... Business Tel # ( ) .....Citizenship.....

Business Address .....
City State Zip

Parents: ☐ Married ☐ Divorced ☐ Separated ☐ Widowed ☐ Single

◆ **Name of Legal Guardian** (if neither of above): .....

Address .....
City State Zip

Day Phone # ( ) ..... Night Phone # ( ) .....

◆ Names and Ages of Siblings .....

.....

◆ Grandparents' Names ..... Grandparents' Names .....

Deceased ☐ Deceased ☐

Address ..... Address .....

Telephone # ..... Telephone # .....

◆ **Emergency contact**, in the United States, if parent or guardian not available:

Name..... Relationship to applicant ..... Phone # ( ) .....

PERSONAL INFORMATION

There are no ***"correct"*** answers in this section and short replies will not harm your application.

1. What activities are you (or have you been) involved in at school? .....

   .....

2. Describe your activities outside of school. Do you hold any office or leadership positions? .....

   .....

3. What are your special interests, hobbies, or talents?

   Please check areas of talent or interest ☐ Singing ☐ Playing a musical instrument ☐ Art ☐ Acting
   ☐ Videography ☐ Public Speaking ☐ Writing/Creative Writing ☐ Photography ☐ Computer "Techie" ☐ Other

   Would you bring a musical instrument with you on the March? ☐ Yes ☐ No What instrument? .....

4. Describe yourself as you see yourself, both your strengths and weaknesses. .....

   .....

5. Describe yourself as others see you, both your strengths and weaknesses. .....

   .....

6. Have you suffered a significant recent loss? Please describe. .....

   .....

7. Are any of your immediate family members survivors of the Holocaust? .....

   Relationship .....

8. Did you lose any close family relatives in the Holocaust? .....

   Relationship .....

9. What type of religious service do you ordinarily attend? ☐ Orthodox ☐ Conservative
   ☐ Reform ☐ Reconstructionist ☐ None

   Synagogue Affiliation ☐ Yes ☐ No Name of Synagogue .....

   Would you be willing to help lead songs, prayers, or religious services? ☐ Yes ☐ No

   Please specify .....

10. Have you ever been in trouble with the law? ☐ Yes ☐ No If yes, please explain .....

    .....

Note: Please be aware that while all food on the March of the Living is Kosher, we cannot provide for special dietary needs. Contact your local agency to discuss special needs.

EDUCATIONAL INFORMATION

[no abbreviations please]

1. GENERAL EDUCATION

Name of current High School..... Grade as of September 1..... Date of Graduation.....

School Address.....
Street City State Zip

Principal's Name .....

If attending College

Name of College ..... Year.....

School's Address.....
Street City State Zip

2. Jewish Day School Education

Elementary School..... Dates Attended .....

Address .....
Street City State Zip

Junior High School .....Dates Attended .....

School's Address.....
Street City State Zip

3. After School - Weekend Religious School Education

Name of Synagogue, School, or Teacher .....Dates Attended.....

Address .....
Street City State

4. Other Jewish Programs: Youth Groups, Educational Programs, Leadership Workshops, etc. (include dates)

....

....

5. Summer Camp and/or Travel Experience, secular or Judaic (include dates)

....

....

6. Israel Experience

Program Attended ..... Date(s) Attended.....

Family or Independent Travel ..... Date(s) .....

7. Have you ever been to Poland before? Yes ☐ No ☐ Date(s).....

Describe Program .....

.....

APPLICANT'S STATEMENT

I hereby agree to enroll in the March of the Living Program, a highly intensive Jewish educational experience, to participate fully in all its aspects and to abide by all its rules and regulations. I acknowledge the fact that usage or involvement with alcoholic beverages, drugs or narcotics, or any other type of anti-social behavior including failure to abide by its rules and regulations may be cause for my immediate dismissal from the program and my return to the United States at my own expense.

On the Medical Form enclosed, I have read the Notes to the Examining Physician. I hereby certify that the Medical Form is complete in detail and fully realize that any condition, mental or physical, that is found to have originated prior to my departure, and which is not described in full on this form or in an accompanying letter submitted prior to departure, will be due cause for my return or treatment in the country I am visiting at my expense, and that the March of the Living and its representatives have neither responsibility nor liability arising out of such condition. Furthermore, all medication that I take regularly is detailed in the Medical Form or accompanying letters.

Applicant's Signature ..... Date.....

PERMISSION FORM

I hereby give..... (name of participant) permission to participate in the March of the Living Program.

I agree to hold the leadership of the March of the Living, its representatives and staff, harmless from any liability arising out of transporting and supervising, or any other activity pertaining to this program for the above named participant, and agree to indemnify the sponsors of the March of the Living and its employees for any costs for the above named participant which may arise in connection with this trip.

I give my full permission for all treatment of any nature deemed necessary by doctors in Europe, Israel or USA to be extended to my child within the framework of the medical services provided by the March of the Living leadership.

I have read my child's statement above and agree to all its statements and conditions.

Signature of Parent or Guardian ..... Date.....

ESSAY

Write a short essay on ***"Why I Would Like To Participate In The March Of The Living."*** It is to be printed or typewritten, not to exceed 500 words, or two typewritten pages.

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YOUTH
Medical Data Form

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Please return this completed form to Our New York/New Jersey Regional Office
1 Eventide Court
Morris Plains, NJ 07950

PART 1 – FOR THE APPLICANT

1. This Medical Form must be filled out by a physician who is not related to you and has known you for at least 18 months. In addition, if you are under the care of a specialist, (i.e. cardiologist, neurologist, psychiatrist, psychologist, social worker, physical therapist, etc.) you must submit a written report from a specialist detailing your diagnosis, treatment, and prognosis. Failure to submit such a report can result in your expulsion from this program without any return of funds.
2. If you don't have a physician, contact your local agency for instructions.
3. If you will be taking prescription medication while on this program you must submit a written report giving full details of each medication. It is advisable to travel with a written generic prescription for each medication. You must also bring two complete sets of your medication with you.
4. If any changes take place in your medical or emotional condition within ten (10) days prior to departure of this program, you must immediately submit a full explanatory letter, signed by an appropriate, qualified medical or psychological professional, detailing your diagnosis, prognosis, and treatment. Failure to submit such a report may result in your expulsion from this program without any refund.
5. It is our intention to rely on this completed form and supplementary letters in determining your acceptance and participation in this program. Omissions or misstatements are at your risk and that of your physician(s) or therapist(s).
6. Should you be found to have any condition, mental or physical, that is not fully disclosed in this Medical Form or in an accompanying letter from an appropriate, qualified medical or psychological professional, then:
   (a) you may, at the sole and absolute discretion of the program, be returned to the USA at your own expense, or be treated in the country(ies) you are visiting, at your own expense, without monetary refund.
   (b) the leadership of this program and its sponsoring organizations are hereby released from all responsibility or liability of any kind whatsoever arising out of any aspect of your medical history and mental or physical condition.

PERSONAL HEALTH HISTORY

To be completed by the applicant. Fill in every answer. Do not leave any blank spaces.
When not applicable, write N/A. All information will be treated confidentially.

Name:.....

Birth Date: ..... Sex: ☐ Male ☐ Female Email .....

Home Address .....

.....

City State Zip

Medical Insurance (company): .....Company Policy No. ..... **[Submit copy of your insurance record/card]**

Family History:

Father's Name ..... ☐ Living ☐ Deceased Date of Death..... Cause of Death.....

Mother's Name..... ☐ Living ☐ Deceased Date of Death..... Cause of Death.....

Brother(s) ..... Sister(s) Number .....

☐ Living ☐ Deceased Cause of Death .....

Mark an "X" in the box next to the medical condition listed below that applies to your health history:

- ☐ Anemia
- ☐ Arthritis
- ☐ Asthma
- ☐ Bleeding Disorder
- ☐ Bronchitis
- ☐ Chemical Dependency
- ☐ Chicken Pox
- ☐ Convulsions/ Neurological Disorders
- ☐ Diabetes
- ☐ Eating Disorders
- ☐ Epilepsy
- ☐ Eye Ailments
- ☐ Fainting
- ☐ Frequent Colds
- ☐ German Measles
- ☐ GI/Stomach Problems
- ☐ Headaches
- ☐ Heart Ailments
- ☐ Kidney Ailments
- ☐ Measles
- ☐ Mononucleosis
- ☐ Motion sickness/Vertigo
- ☐ Mumps
- ☐ Orthopedic Fractures
- ☐ Pneumonia
- ☐ Poliomyelitis
- ☐ Psychological Problems
- ☐ Rheumatic Fever
- ☐ Scarlet Fever
- ☐ Sinusitis
- ☐ Sleep Walking
- ☐ Thyroid Condition
- ☐ Tuberculosis
- ☐ Tumors

Visual

- ☐ Eye Glasses
- ☐ Contact Lenses

Allergies:

- ☐ Hay Fever
- ☐ Insect Stings
- ☐ Penicillin
- ☐ Other .....

Female only:

- ☐ Regular Menstrual Cycle
- ☐ Menstrual Problems

1. If you checked any of the above please give all details including name(s), date(s) and address(es) of physicians and hospitals.

.....

.....

..... Date of Illness: .....

2. Do you have problems with eating? .....

.....

3. Have you undergone any operations or sustained any injuries? .....

If yes, give details, including dates, names and addresses of physicians and hospitals below. .....

.....

4. Are you taking any medication now? If so, please state name of medication, name of physician and condition being treated. .....

.....

.....

.....

5. Condition of health: .....

Date and nature of last illness.....

6. Describe any disabilities or restrictions.....

If none, write "none." .....

7. Are you able to participate in a strenuous program?.....

.....

8. Have you ever been in any kind of physical therapy? If so, please indicate:

Person consulted..... Profession..... Date(s) of consultation.....

Reason .....

9. Have you ever been in any kind of psychological or social therapy? If so, please indicate:

Person consulted..... Profession..... Date(s) of consultation.....

Reason .....

10. Signature of applicant .....

Signature of parent if applicant is a teen participant.....

PART 2 - FOR THE PRIMARY CARE PHYSICIAN

NOTES TO THE EXAMINING PHYSICIAN

1. **Each March participant will face a new and strenuous environment, which will be physically and 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 disturbances.**

2. This form should only be completed by you 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 service the applicant.

3. **If the applicant is required to continue receiving medication while participating in the program, he/she should be given a medical letter giving full details. Since medicine is not often available under the same trade name as in the United States, the full generic name should be given.**

4. It is our intention to rely on this completed form and supplementary letters in determining the final acceptance of the applicant into this program.

5. If you become aware of changes in the applicant's medical or psychological condition, please notify the central office of the March of The Living.

6. The information on this report and all supplementary material shall be held strictly confidential.

7. If you have any concern about the participation of the patient in this program, please contact the office of the **March of the Living** below.

LOCAL AGENCY OR FEDERATION

PHYSICAL EXAMINATION

(to be completed by a licensed physician)

	Normal	Abnormal	Describe Abnormality
HEIGHT	.....	.....	.....
WEIGHT	.....	.....	.....
BLOOD PRESSURE	.....	.....	.....
ALLERGIES	.....	.....	.....
DRUG ALLERGIES	.....	.....	.....
General Build	.....	.....	.....
Head	.....	.....	.....
Ears	.....	.....	.....
Eyes	.....	.....	.....
Nose	.....	.....	.....
Throat	.....	.....	.....
Neck	.....	.....	.....
Chest, lungs	.....	.....	.....
Heart	.....	.....	.....
Abdomen	.....	.....	.....
G.U. System	.....	.....	.....
Extremities	.....	.....	.....
Spine	.....	.....	.....
Skin, Lymphatics	.....	.....	.....
Nervous System	.....	.....	.....
Mental/Psychological State	.....	.....	.....

☐ significant past illnesses or emotional problems which might have a bearing on the participant's health while he/she is away.....

.....

☐ present physical or emotional problems.....

☐ medications - If so, list detailed prescription and exact instructions.....

.....

☐ dietary restrictions.....

☐ restrictions on physical activity.....

Required: Optional

☐ Tetanus Date ..... ☐ Influenza Date ..... ☐ Pneumococcus Date ....

My recommendations are as follows: .....

.....

.....

Name of Doctor .....

Address .....

Telephone # ( ) .....Date .....

Stamp & Signature Of Physician.....License# .....

PHYSICIAN'S STATEMENT

Name of Applicant: ..... Email .....

I have read the above medical form and thereafter have examined the above named participant and have recorded the results above which represent, to the best of my knowledge, all of 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.

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

* If you become aware of a change in the applicant's medical condition, please notify the:

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AND

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