ADAMAH APPLICATION

Note: Adamah fellows are required to have health insurance. If you are accepted into the program, you will be required to share you health insurance info. If you do not currently have health insurance, you can get an income based plan including free medicaid if you qualify. Visit www.healthcare.gov to sign up.

PART I – GENERAL INFORMATION

Applicant Information

Name: ____ Age at Program Start: __________

Street Address: _______________________________________ Date of Birth: ___/___/______

City: _______________________ State: ___ Zip: _________

Phone: _____________________ E-mail: ______________

What are your pronouns? (they/them, he/him, ze, she/her, etc) ______________________________________

Season applying for: ☐Spring ☐ Summer ☐ Fall

What is your housing preference?

☐ Tent (we provide a tent on a platform) ☐ Adamah House (indoors with a roommate) ☐ Either

Parent/ Guardian 1

Name: _________________________________

Relationship to Applicant _________________

Address: _______________________________

City/State/Zip: __________________________

E-mail: ________________________________

Phone: ________________________________

Parent/ Guardian 2

Name: _________________________________

Relationship to Applicant _________________

Address: _______________________________

City/State/Zip: __________________________

E-mail: ________________________________

Phone: ________________________________

Emergency Contact (if different from above)

Name: _________________________________

Relationship to Applicant: _______________

Home Phone: ___________________________

Cell: ___________________________________

Email Address: __________________________

Work Phone: ____________________________

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PART II: TELL US ABOUT YOURSELF

This information we use to help us form a diverse, pluralistic community. No applicant will be judged solely on the basis of a single application question! Although no formal experience in Judaism or agriculture is necessary, it is helpful for us to know where you are coming from.

Please describe your experience and/or education in Judaism.

Please describe any training or education you have had in fields related to the environment or agriculture.

Please list any training and experience you may have in conflict resolution or intentional communal living.

Short Answer Section:

Please provide brief answers (3 to 6 sentences) to the following questions.

Describe an experience you have had of group living (outside your family)

What are your strengths? What brings them out?

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Adamah is committed to honoring the diversity of the Jewish community, and welcomes participants from across the spectrum of belief, Jewish observance, gender identity, and sexuality.

What are your thoughts on living, learning, and practicing with people who:

- have different religious practices than you
- have different gender identities and sexual orientations than you
- or have different positions on political, economic, and social issues?

What else would you like us to know about you as a potential Adamah Fellow?

Applicant Personal History

If any of the following apply to you, check the box next to the item and provide details on the spaces below.

Do you have a history or current problem with substance abuse or dependency?

☐ Yes. ____

Have you been on probation or had any involvement with the justice system

☐ Yes. ____

Can you swim? ☐ Yes ☐ No

What is your biking ability?

☐ Strong Biker ☐ Know how to ride ☐ Don’t know how to ride a bike, but willing to learn

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Essay Section:

In 500 words or less, describe why you want to participate in Adamah and what you hope to gain from the Fellowship. Please include some discussion of your personal Jewish journey and your interest and involvement in farming and sustainability. How does participating in Adamah fit into where your are heading on your life path?

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PART III APPLICANT MEDICAL HISTORY: PAST AND PRESENT

Immunizations

Please note that we require that all of our participants provide Adamah with medical documentation of up to date tetanus and MMR (mumps, measels, rubella) immunization.

A. MEDICAL CONDITIONS

Do any of the following apply to you?

If YES check the box next to the item and provide detail in the spaces below. Include the following:

- Specific symptoms that are occurring
- How long symptom/condition lasts
- Date of last occurrence
- How often symptom/condition occurs
- How you care for symptom/condition
- Any restrictions

CONDITION SYMPTOMS/RESTRICTIONS

☐ High Blood Pressure ____

☐ Heart Disease ____

☐ Heart Murmur ____

☐ Irregular Heartbeat/Palpitations ____

☐ Chest Pain/Pressure ____

☐ Circulation Problems ____

☐ Frostbite ____

☐ Heatstroke ____

☐ Frequent Dizziness/Fainting ____

☐ History of Altitude Sickness ____

☐ Severe Headaches/Migraines ____

☐ Head Injury w/Neurological Impairment ____

☐ Tuberculosis/Positive TB test ____

☐ Asthma or COPD ____

☐ Active or History of Hepatitis ____

☐ Lyme Disease ____

☐ Seizure Disorder/Epilepsy ____

☐ Seizure within past 6 months ____

☐ Bleeding/Blood Disorder ____

☐ Sickle Cell Anemia ____

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☐ Sickle Cell Trait ____________________

☐ Hypoglycemia (low blood sugar) ____________________

☐ Diabetes ____________________

☐ Cancer ____________________

☐ Thyroid Problems ____________________

☐ Gastro-intestinal Problems ____________________

☐ Special Diet ____________________

☐ Food Allergies ____________________

☐ Kidney Problems ____________________

☐ Urinary Tract Problems ____________________

☐ Bedwetting ____________________

☐ Orthopedic Problems ____________________

☐ Broken Bones within past year ____________________

☐ Hearing Impairment ____________________

☐ Vision Impairment ____________________

☐ Skin Problem ____________________

☐ Motion Sickness ____________________

☐ Sleep Walking ____________________

☐ PMS/Menstrual Problems (severe) ____________________

☐ Currently Pregnant ____________________

☐ Medical Equipment/Devices ____________________

☐ Other (please describe and use as much space as you want)

B. ALLERGIES

Please list any allergies you may have.

Include allergies to medicine, foods, insect bites/stings, environmental, etc.

Allergy	Reaction	Medication Required, if any
____________	____________	____________
____________	____________	____________
____________	____________	____________
____________	____________	____________

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C. MEDICATIONS

Please all medications you are currently taking.

If psychiatric medication, please list any medications taken or changed within the past 3 months.
Also, list any over-the-counter, inhalers, herbal supplements, etc.

Medication List Below	Taken For Symptom/Condition	Dosage Size/Freq.	Date Started	Current Side Effects	Expiration Date
____________	________________	__________	__________	________________	__________
____________	________________	__________	__________	________________	__________
____________	________________	__________	__________	________________	__________
____________	________________	__________	__________	________________	__________
____________	________________	__________	__________	________________	__________

NOTE: If you are taking prescription medications, you MUST bring them in ORIGINAL PRESCRIPTION BOTTLES with the physician's dosage directions. If possible, bring a double supply. Any changes to the above noted medications or dosages prior to course must be shared with Adamah as soon as possible.

D. HOSPITALIZATIONS/EMERGENCIES

Please list any hospital, psychiatric, or urgent care visits within the past year.

Date of Visit / Admittance	Reason	Length of Stay
________________________	_________________________	_____________________________
________________________	_________________________	_____________________________
________________________	_________________________	_____________________________

E. MEDICAL DETAILS

Do you have a medical ID? (bracelet or necklace)

☐ No ☐ Yes If yes, please explain: ____

Blood Pressure

Blood pressure may be taken with apparatus at a local grocery or drug store.

Blood Pressure: ___________ Date Taken: ___________ *(Must be within 1 year of course start)*

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G. PSYCHIATRIC AND MENTAL HEALTH CONDITIONS

Do any of the following apply to you?

If YES, check the box next to the item and provide details on the spaces below.

☐ ADHD
☐ Autism Spectrum Disorder
☐ Anxiety Disorder
☐ Bipolar Disorder
☐ Depressive Disorder
☐ Disruptive and Conduct Disorder
☐ Eating Disorder
☐ Intellectual Disability
☐ Learning Disability
☐ Obsessive Compulsive Disorder
☐ Personality Disorder
☐ Schizophrenia Spectrum Disorder
☐ Substance Related Disorder
☐ Trauma and Stressor Related Disorder
☐ Other: ________________

Please Describe:

Have you received treatment or therapy for any of the above, either currently or in the past?

If YES check the box next to the item and provide detail on the spaces below?

☐ Medication(s)
☐ Residential Treatment
☐ Therapy / Counseling
☐ Psychiatric Hospitalization
☐ Day Treatment

Please Describe:

If you checked any of the above, please provide the following information for your therapist and/or prescribing physician.

Prescribing Physician Name: ________________

Phone Number: ________________

Fax Number: ________________

E-mail: ________________

Therapist / Counsellor Name: ________________

Phone Number: ________________

Fax Number: ________________

E-mail: ________________