University of Life Sciences in Lublin

HEALTH CERTIFICATE

(*Filled and signed by a physician*)

 **PERSONAL DATA**

1. Surname ..................................................... first name (s) ............................................

 father`s first name .............................................. mother’s first name .....................................

2. Date of birth: year ............. month .............. day ............. place ..............................................

3. Contact address: country ........................................................

street, number ....................................................... code ............. city ........................................

## PREVIOUS MEDICAL RECORD

4. Candidate’s medical history:

a) congenital or acquired disability ...........................................

b) chronic conditions: diabetes, asthma, hypertension, rheumatic, allergies, psychiatric, neurological, others ......................................................................................................................

c) medication (temporary/longstanding) ......................................................................................

d) hospitalization, date, diagnosis ...............................................................................................

5. Family diseases ........................................................................................................................

6. Other information .....................................................................................................................

## MEDICAL EXAMINATION

7. Height .................... cm, weight ............... kg

 Blood pressure ......................... pulse ............................ per minute

8. Physical examination of the systems .......................................................................................

 observations .............................................................................................................................

9. Vision .............................. glasses/correction Rt. ............................. Lt. .................................

10. General blood and urine tests .................................................................................................

11. Tuberculin test: date .............................. result ......................................................................

12. Chest X-ray (can be separately done) date .......................... result.........................................

**VACCINATIONS**

13. Please indicate the date of last vaccination:

Tuberculosis…………………………………………………………………………………….

HBV…………………………………………………………………………………………….

**MEDICAL CONCLUSION** (delete, if not applicable)

14. Candidate is in a good health with no contraindications for studying YES/NO

15. Physician`s name and signature:

place ............................ date ............................... signature..........................................................

 Official stamp, address, phone number or fax.