# **MEDICAL FORM**

### **CONFIDENTIAL**

The medical forms are collected, opened, and handled confidentially by the designated services provider, the CEU Medical Center.

## I. MEDICAL HISTORY

the exa	amining physi	_	a signea i	before visiting
1. NAME:				
	First	М	iddle	
2. CEU DEPARTMENT/PROGRAM:				
3. DATE OF BIRTH:	4. GENDER:	Male	Female	
(month /day / year)				
5. CITY & COUNTRY OF ORIGIN:				
or CITY & COUNTRY OF PERMANENT RESIDENCE				
6. PRESENT HOME ADDRESS:				
Street & No.		 City		Country
		,		,
7 Indicate VES or NO VES answers MUST be eval	ainad in chaca	provided (a	dditional (	space provided on th
7. Indicate YES or NO. YES answers MUST be explorerse side of this page)	аттей тт ѕрасе	provided (a	uullional s	space provided on th
reverse side of this page,				
	YES		NO	
a. Have you ever had any significant or	_			
serious illness or injury? (State nature of	i			
problem/place/dates) b. Have you ever had any operations or				
been advised by a physician to have an				
operation?				
(Describe and give place/dates)				
c. Have you ever been a patient in a				
mental hospital or sanatorium or				
treated by a psychiatrist?				
d. Do you currently use any medication				
for treatment of a medical condition?	1			

(List name/dose)

treatment and outcome:
9. Please indicate who should be notified in case of emergency:
Name:
Address:
Telephone number(s):
or (alternate):
Name:
Address:
Telephone number(s):
I certify that I have reviewed the foregoing information provided by me, and that it is true and complete to the best of my knowledge.
I understand that if any of this information is found to be substantially inaccurate or incomplete, the insurance company will not cover the costs of my medical services.
Signature:
Date: (month /day / year)

### II. PHYSICAL EXAMINATION FORM

This physical examination form must be completed in English by a designated and qualified physician after reviewing the examinee's medical history (Part 1), physical examination, and assessment of laboratory and X-ray results. The examining physician must make comments on this form on all positive and/or significant findings and sign where indicated.

1. STUDENT'S NAME: _				
	(Last	First	Midd	dle)
2. HEIGHT: 3. WEIGHT:			D VISION: 20:	20:
(cm)	(kg)		L	R
5. BLOOD PRESSURE: _	6.	PULSE:		
	(syst./diast.)	(rate/reg	ular or irregular)	
7. URINANALYSIS:(su	ugar) (albumin)	(microscopic	examination)	
8. ELECTROCARDIOGRA	AM REPORT (necessary	only if indicated by l	nistory or physical ex	kamination):
9. PREGNANCY TEST (n	ecessary only in case of	suspected pregnan	cy): pos	neg
10. BCG VACCINATION	- BCG Vaccine Given:	No Yes	Date of Series:	<i></i>
11. Chest X-ray not old	er than 6 months to rule	e out active tubercu	osis.	
Date & Result of	of Chest X-ray :/ (month /c	/ Result: lay / year)		

12. CLINICAL EVALUATION: (Every item checked "abnormal" must be fully explained in the blank space on the right.)

N	ORMAL	(Check Each Item)	ABNORMAL	DESCRIE	BE ABNORMAL FINDINGS
		Head, Nose, Mouth			
		Ears, Hearing Acuity			
		Eyes, Visual Acuity			
		Lungs and Chest/Breast			
		Heart, Rhythm & Sounds			
		Vascular System,			
		Varicosities			
		Abdomen, Hernia etc.			
		Haemorrhoids, Fistula,			
		Prostate/Rectum			
		Urinary System			
		Spine, Arms, Legs etc.			
		Skin, Lymph Nodes, Scars			
		Neurological			
		System/Reflexes			
		Emotional Stability			
I have comp	e reviewe oleted my vledge.	physical examination. I certif n that the student's physical a	ry, laboratory evalu y that the student and emotional con	is free from conta	t, immunisation record, and have agious diseases to the best of my ory for full course study, research,
	_	n an academic environment he duration of the studies.	and that there ar	e no limitations	on activity or special assistance
YES	NO				
		Signature	Prin	ted name of Phys	sician
		Date	Country W	/here Licensed	Number
		Address of Physician			

## **III. IMMUNISATION RECORD**

This Immunisation Record form must be completed in English by a designated and qualified physician.

No mandatory vaccination is required to enroll in CEU. Please indicate the exact dates of all vaccinations. If one of the dates are unknown please leave the relevant line blank.

Name:			
L	ast First	Middle	Date of birth (month/day/year)
	VACCINE	DATE (month/day/y	CEU ONLY
<b>Diphteria/tetar</b> Most recent boo	nus series (Td) oster within 10 yrs		
Measles, mump	os, rubella (MMR) twice	#1// #2//	
OR all o	of the below:	#2	•
Measles (rubeo	a)		
either:	1. 2 vaccinations	#1// #2//	
or	Physician documented     (MD signature required)		
or	3. Laboratory evidence of	f disease:	
	Immune		
Mumps			
either:	1. Vaccination		
or	2. History of disease	//	
or	3. Laboratory evidence of	f disease:	
	Immune		
Rubella (Germa	n Measles, Morbilli)		
either:	1. Vaccination (after 196	9)/	
or	2. Laboratory evidence o	f disease:	
	Immune	, ,	

Date of test:// (month /day		Resu	ult:
OLIOMYELITIS VACCINE, any	one of the following pr	rimary series	
Salk-Injections Inactivated Polio Vaccine (at least 4)	Sabin-Oral Live Vi MONOVAL (at least .	ENT	rbin-Oral Live Virus Vaccine TRIVALENT (at least 3)
DATE (month /day / year)	DATE (month /day	/ / year)	DATE (month /day / year)
1 2 3 4	Type I: Type II: Type III:	2	
Booster:			oster: oster:
or documentation of positi lease record ALL OTHER IMMUI tc.):			Date:// (month /day / year) Typhus, Yellow Fever, Plague, R
DATE (month /day / year)	ТҮРЕ	SERIES/BOOST	ER

DATA HANDLING ENDORSEMENT
Hereby I give my explicit approval to the CEU Medical Center to handle with utmost confidentiality my personal data regarding my medical history and the related occasional medical treatment, according to the data protection law. I agree to forward my medical data to the insurance company insuring me during my studies at CEU in order to evaluate my insurance reimbursement.
NAME (Printed letters):
DATE: //(month / day / year)
SIGNATURE: