HEALTH CERTIFICATE FORM

STUDENT INFORMATION

Last Name _____ First Name _____ Middle Name _____

Age _____ Sex ☐ M ☐ F Date Examined _____

MEDICAL INFORMATION
(to be completed by a physician)

Have you examined the applicant for any illness? ☐ Y ☐ N

If so, explain _____

_____

Has the applicant been treated for any of the following?

☐ Tuberculosis ☐ Diabetes ☐ Hearth disease ☐ Anemia ☐ Migraine

☐ Asthma ☐ Rheumatic Fever ☐ Epilepsy ☐ Thyroid Disorders

☐ Depression ☐ Psychotic Disorders ☐ Anxiety Disorders

If so, explain _____

_____

Does the applicant have any disability, which may interfere with his/her studies? ☐ Y ☐ N

If so, explain _____

_____

Has the applicant received treatment or been admitted to a hospital for mental disorders? ☐ Y ☐ N

If so, explain _____

_____

Does the applicant have any abnormalities in the following?

☐ Skin ☐ Head ☐ Inmune System ☐ Endocrine System ☐ Abdomen

☐ Spine ☐ Heart ☐ Vascular System ☐ Nose & Sinus

☐ Ears ☐ Chest ☐ Lymph nodes ☐ Neurological System

If so, explain _____

VITAL SIGNS

☐ Temperature ☐ Blood Pressure

☐ Pulse ☐ Breathing

Does the applicant have any vision problems? ☐ Y ☐ N

If so, explain _____

Has the applicant received all immunizations? ☐ Y ☐ N

After examining the applicant, do you find him/her fit for any form of mental and/or physical activity? ☐ Y ☐ N

PHYSICIAN INFORMATION

Name _____

Address _____

Telephone (please include area code) _____

_____ _____

Signature and Stamp Date

Please note this form is not valid without the Doctor's stamp

Instructions
Please, mail this form with the application for admission form and all other required documents to: