HEALTH DECLARATION FORM

I. Declaration of the applicant

LEGAL NAME *(WRITE NAME EXACTLY AS IT APPEARS ON OFFICIAL DOCUMENTS)*

FIRST/GIVEN NAME: _____

FAMILY/SURNAME: _____

MOTHER'S MAIDEN NAME: _____

PERMANENT (HOME COUNTRY) ADDRESS: _____

_____

PLACE AND DATE OF BIRTH *(MM/DD/YYYY)*: _____

HUNGARIAN CELL PHONE (IF ANY): +36 (20/30/70) _____ - _____

EMAIL:_____ @ _____

Please read the questions of this declaration carefully and respond to them precisely. Please note this form will be passed on to the university doctor. All information provided will be treated with the strictest confidence.

Body weight: ……kg Body height:…… cm Do you have any problems with hearing? **No / Yes**

Smoking: **No / Yes / Quit smoking**

Alcohol consumption: **No / Casually / Yes** Do you have drug or alcohol dependency? **No / Yes**

Any personal history of previous illnesses: **No / Yes** *(list, if the answer is 'yes')*:

…….....……

Do you receive any medical treatment because of current illnesses? **No / Yes** *(please indicate the reason)*

……

Do you take medication regularly (contraceptive pills)? **No / Yes** *(list, if the answer is yes'):*

..……...……

Have you got glasses or contact lenses? **No / Yes**: .....Diopter? Right: ……..... Left: .....……

Are you allergic to any material, medicine, etc? **No / Yes** *(list, if the answer is 'yes'):*

……

Have you ever had a fracture or blackouts? **No / Yes** *(if the answer is 'yes', when):* ……...…….

Have you had any operations/surgery/severe accidents? **No / Yes** *(list, if the answer is 'yes'):*

……..……..……..

Do you have allergies? **No / Yes** *(list, if the answer is 'yes'):* ……..

Do you have a Driving Licence? **Yes / No** (*MM/DD/YYYY*)

Any infectious diseases in the past or currently? **Yes / No** *(list, if the answer is 'yes'):*

……..……..……..

Have you been vaccinated against Hepatitis B? **No / Yes (***if the answer is 'yes' indicate the date(s)***)**: ……...*****

Chronic illnesses or conditions in your family:

Mother: ……

Father: ……

Brothers/Sisters:……

Please, tick (√) the appropriate box below:

- ❑ I declare that I suffered from **Varicella (chickenpox)**. Date(s) *(MM/DD/YYYY)*: …….....
- ❑ I declare that I received Varicella vaccination.* Date(s) *(MM/DD/YYYY)*: …….....
- ❑ I declare that neither I suffered from Varicella nor did I receive Varicella vaccination.
- ❑ I cannot provide information.

- ❑ I declare that I suffered from **Rubeola-Rubella (German measles)**. Date(s) *(MM/DD/YYYY)*: ……..
- ❑ I declare that I received Rubella vaccination.* Date(s) *(MM/DD/YYYY)*: …….....
- ❑ I declare that neither I suffered from measles nor did I receive Rubella vaccination.
- ❑ I cannot provide information.

- ❑ I declare that I suffered from **Morbilli (measles)**. Date(s) *(MM/DD/YYYY)*: …….....
- ❑ I declare that I received Morbilli vaccination.* Date(s) *(MM/DD/YYYY)*: ……..…….....
- ❑ I declare that neither I suffered from measles nor did I receive Morbilli vaccination.
- ❑ I cannot provide information.

I CERTIFY THAT ALL THE ABOVE MENTIONED INFORMATION AND ANY OTHER SUPPORTING MATERIALS - ARE FACTUALLY TRUE, AND HONESTLY PRESENTED, AND THAT THESE DOCUMENTS WILL BECOME THE PROPERTY OF THE INSTITUTION TO WHICH I AM APPLYING AND WILL NOT BE RETURNED TO ME. I UNDERSTAND THAT I MAY BE SUBJECT TO DISCIPLINARY ACTION, SHOULD THE INFORMATION I HAVE CERTIFIED BE FALSE.

STUDENT'S SIGNATURE:…… PLACE AND DATE:…….....
(MM/DD/YYYY)

II. Declaration of your General Practitioner

The individual mentioned above is at present free from signs and symptoms of infection. It is hereby certified that he/she is physically and mentally fit to pursue university studies in the field of health sciences.

***Remarks**:*

_____

NAME AND ADDRESS OF THE DOCTOR: _____

PLACE AND DATE: _____ **SIGNATURE AND STAMP**: _____
(MM/DD/YYYY) (*REGISTRATION NUMBER OF THE DOCTOR)*

IMPORTANT NOTICE:
The University of Szeged, Faculty of Medicine/Dentistry/Pharmacy/Health Sciences and Social Studies requires the following medical documents after acceptance as an attachments of this form **in a closed envelope**:

- **Hepatitis-B blood test** paper based result (Anti-HBsAg >10 mIU / ml)
- **Hepatitis B vaccinations** (minimum of 2 shots required)
- **Hepatitis-C blood test** paper based result
- **HIV blood test** paper based result
- **Copy of your Vaccination Card** or **Immunization Record** issued by your GP
- **Chest X-ray paper based result** (CD/X-ray is NOT required)

Please note: medical tests have to be taken after January 1, 2019. In the case of any controversy, the examinations may have to be repeated at the University of Szeged, in Szeged, Hungary.