Health Form

Sex: F ( ) M ( )

Date ____________ Social Security Number or similar ____________ Date of Birth ____________ Birthplace ____________

Last Name ____________ First Name ____________ Middle Name ____________ Maiden Name ____________ Preferred Name ____________

Permanent Home Address (Street and No.) ____________ City ____________ Country ____________ Phone ____________

Next of Kin ____________ Relationship ____________ Address ____________ Phone ____________

Do you have a permanent physical disability? ( ) No ( ) Yes If yes, please explain:

____

Do you have a problem that would limit your education activities? No ( ) Yes ( ) If yes, please explain:

____

Do you have now or have you ever had any condition, illness, or disease? No ( ) Yes ( ) If yes, please check all that apply (with dates):

Now	Past	Problem
		Anemia
		Arthritis
		Asthma
		Back trouble
		Blind/Visual impairment
		Bronchitis/Emphysema/COPD
		Cancer/Malignancy
		Deaf/Hearing impairment
		Depression
		Diabetes
		Eating Disorder (Anorexia/Bulimia)
		Emotional/Mental illness
		Epilepsy (seizure disorder)
		Head injury with unconsciousness
		Heart Disease
		Hepatitis
		High Blood Pressure
		High Cholesterol
		HIV infection/disease
		Hypoglycemia (low blood sugar)
		Impaired mobility/Paralysis

Now	Past	Problem
		Jaundice
		Kidney Disease
		Malaria
		Migraines/Headaches
		Mononucleosis
		Nervous Breakdown
		Neuromuscular Disease
		Phlebitis/Deep vein clot
		Pneumothorax
		Positive TB test
		Sickle Cell Disease
		Sinusitis
		Spastic colon
		Stroke
		Suicidal tendencies
		Thyroid Disease
		Tropical Disease
		TB/Tuberculosis
		Ulcer/Stomach problem
		UTI's (frequent)
		Other

List dates and reasons for significant hospitalizations OR surgery:

Date	Reason

AUTHORIZATION FOR EMERGENCY MEDICAL TREATMENT

I hereby grant Medical University of Lodz permission to authorize emergency medical treatment or surgical treatment for the above named student. I understand that the University will make arrangements without assuming financial responsibility.

Approval: No Yes (Circle One)

Parent's signature required if student is under 18.

Signature of Student ____________ Date ____________ Signature of Parent or Legal Guardian ____________ Date ____________

Emergency Contact: ______________________________ **Phone:** ____________

Medical University of Lodz strongly encourages each student to have Health Insurance coverage. Please send a copy of your insurance card. If you do not have coverage, please request an information regarding affordable health insurance coverage.

Health Insurance: Name and Address of Carrier ______________________________ Policy Number ____________

Send completed form to:
Medical University of Lodz, Division of Studies in English, Application Documents
1, Hallera Sq., 90-647 Lodz, Poland

Physical Examination Form

Name ____ **Date of Birth** _____________

Date of Exam _____________ **(to be completed only by MD)** __________ **Height** __________ **Weight** __________ **BP** __________ **Pulse**

System	Normal	Describe Abnormality
Skin		
HEENT		
Lungs/Chest		
Breasts		
Heart/Vascular System		
Abdomen (rectal if indicated)		
Genito-urinary		
Pelvic (if indicated)		
Musculoskeletal		
Neurological		
Psychological		
Other:		

CURRENT & CHRONIC PROBLEMS

1. ______________________________ **2.** ______________________________ **3.** ______________________________

IF THE STUDENT IS UNDER CARE FOR A CHRONIC OR SERIOUS ILLNESS, PLEASE ATTACH ADDITIONAL CLINICAL REPORTS TO ASSIST US IN PROVIDING CONTINUITY OF CARE.

Current Medications:

Known Drug Allergies or other Significant Allergies:

Allergy to Medication or to other things	Type of reaction

Recommendations for physical activity: ( ) Unlimited ( ) Limited If limited, please specify:

____

Immunizations Records

PRIOR TO ENROLLMENT ALL STUDENTS MUST HAVE COMPLETED THE FOLLOWING FORM OF REQUIERED IMMUNIZATIONS:

Section A. MMR (Measles, Mumps, Rubella) — Month/Day/Year

______ 1st MMR Dose (Administered after 1st birthday AND after 1/1/1972) _____/_____/_____

AND

______ 2nd MMR Dose (Administered after 15 months of age and at least 28 days after 1st dose) _____/_____/_____

Section B1. Measles — Month/Day/Year

______ 1st Live Virus Dose (Administered after 1st birthday & 1/1/69) _____/_____/_____

AND

______ 2nd Live Virus Dose (Administered after 15 months of age and at least 28 days after 1st dose) _____/_____/_____

OR

______ History of Illness (documented by Health Care Provider) _____/_____/_____

OR

______ Immunity (Proven by Serologic Testing) _____/_____/_____

Section B2. Mumps — Month/Day/Year

______ Live Virus Dose (Administered after 1st birthday & 1/1/69) _____/_____/_____

OR

______ History of Illness (documented by Health Care Provider) _____/_____/_____

OR

______ Immunity (Proven by Serologic Testing) _____/_____/_____

Section B3. Rubella (German Measles) — Month/Day/Year

______ Live Virus Dose (Administered after 1st birthday & 1/1/69) _____/_____/_____

OR

______ Immunity (Proven by Serologic Testing) _____/_____/_____

Note: History of Illness is NOT acceptable

Optional immunizations recommended for good health: Meningococcal Meningitis, Tetanus-Diptheria Immunization booster, Hepatitis B.

An official stamp from a doctor's office, clinic, or health department AND an authorized signature must be provided below confirming required immunizations and physical examination.

______________________________ ______________________________ ____________

Name/License # (Office Stamp) **Clinician Signature** **Date**

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