**HEALTH STATUS REPORT**

Student’s name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date of birth: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  
Home Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Home institution: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Degree programme: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**VACCINATIONS:**

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| **Tet-d = Tetanus-Diphteria**  Vaccination (dd/mm/yy): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_(Booster every 20 years) |
| **MMR** - **mumps, measles and rubella –** (vaccinated two times or you have a history of all diseases):  Vaccinations I (dd/mm/yy): \_\_\_\_\_\_\_\_\_\_\_\_\_  II (dd/mm/yy): \_\_\_\_\_\_\_\_\_\_\_\_\_  OR have you had all the diseases? Yes\_\_\_\_\_\_ No\_\_\_\_\_\_ |
| **Polio** (vaccinated four times as a child): Last vaccination (dd/mm/yy): \_\_\_\_\_\_\_\_\_\_\_\_ |
| **Hepatitis B**: Vaccinations I (dd/mm/yy): \_\_\_\_\_\_\_\_\_\_\_\_\_  II (dd/mm/yy): \_\_\_\_\_\_\_\_\_\_\_\_\_  III (dd/mm/yy) \_\_\_\_\_\_\_\_\_\_\_\_\_ |
| **Tuberculosis** vaccine: Vaccinations I (dd/mm/yy): \_\_\_\_\_\_\_\_\_\_\_\_\_  II (dd/mm/yy): \_\_\_\_\_\_\_\_\_\_\_\_\_  III (dd/mm/yy) \_\_\_\_\_\_\_\_\_\_\_\_\_ |

**THORAX X-RAY,** no later than 3 months prior submitting the report. Is needed if the student has treated   
or otherwise been in close contact with patients with tuberculosis or has clinical symptoms suggesting tuberculosis.

Date of Thorax X-ray (dd/mm/yy): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  
  
Result: **\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**SAMPLES** (only for clinical placements):

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| **HIV,** no later than two weeks prior submitting the report.  **Result:** Date of negative sample (dd/mm/yy): \_\_\_\_\_\_\_\_\_ Date of positive sample (dd/mm/yy): \_\_\_\_\_\_\_\_\_\_ |
| **Hepatitis C:**  **Result:** Date of negative sample (dd/mm/yy): \_\_\_\_\_\_\_\_\_ Date of positive sample (dd/mm/yy): \_\_\_\_\_\_\_\_\_\_ |
| **MRSA** (Methicillin-resistant Stafylococcuc-aureus) specimen from nostrils and skin lesions, no later than two weeks prior submitting the report.  **Result:** Date of negative sample (dd/mm/yy): \_\_\_\_\_\_\_\_\_ Date of positive sample (dd/mm/yy): \_\_\_\_\_\_\_\_\_\_ |

**PHYSICAL AND MENTAL HEALTH REPORT:**

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| **Health Problems / Allergies (also drug allergies):** Yes \_\_\_\_ No \_\_\_\_\_  If yes, please specify: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| **Mental Health Problems:** Yes \_\_\_\_ No \_\_\_\_\_  If yes, please specify: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| **Current medication and dosage:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| **Appearance of any infection diseases?** Yes \_\_\_\_ No \_\_\_\_  If yes, please specify: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |

I prove that the applicant is in good health, no barriers to studies/practical training.

Yes\_\_\_\_\_ No\_\_\_\_\_\_

Name of Health Care Provider: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Title: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  
  
Signature of Health Care Provider: ­­­­­­­­­­­­­­­­­­­­­­\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Official seal or stamp: **\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**