HEALTH DECLARATION FORM

I. DECLARATION OF THE APPLICANT *(TO BE FILLED IN BY THE APPLICANT)*

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

FIRST/GIVEN NAME: ……..

FAMILY/SURNAME: …….....

GENDER: MALE / FEMALE / PREFER NOT TO DISCLOSE *(please underline)*

MOTHER'S MAIDEN NAME: FIRST NAME ……FAMILY NAME ……..

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

PERMANENT ADDRESS (HOME COUNTRY): ……

……

PASSPORT NO.:……..

EMAIL:…… @ …….

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

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.

Bodyweight: ……kg Body height:…… cm

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 have any current illness or chronic disease ? Do you receive any medical treatment? **No / Yes** *(if 'yes', please give details)* ……...

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

..……...……

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

Do you have any problems with hearing? **No / Yes** *(if 'yes', please detail):*……..

Are you allergic to any chemical, material or medicine? Any other allergies? **No / Yes** *(list, if the answer is 'yes'):*

…….

Have you ever had seizures or blackouts? **No / Yes** *(if 'yes', when?):* ……...……..

Have you had any operations/surgeries/severe accidents/injuries (e.g.: bone fractures)? **No / Yes** *(list, if the answer is 'yes'):* ……..……..……...

Do you have a Driving Licence? **Yes / No** *(if the answer is 'yes')* Date of issue (MM/DD/YYYY)……...

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

……..……..……..

Chronic illnesses or conditions in your family:

Mother: ……

Father: …….

Brothers/Sisters:……

Please, tick (√) the appropriate box below:

Have you been vaccinated against **Hepatitis B**?

❑ No ❑ Yes - Dates of the vaccinations *(MM/DD/YYYY)*: ……..

- Booster doses (if any) *(MM/DD/YYYY)*: ……..

Have you suffered from **Morbilli (measles)** ?

❑ No ❑ Yes - Date *(MM/DD/YYYY)*: ……..

Have you been vaccinated against **Morbilli (measles)**?

❑ No ❑ Yes - Dates of vaccinations* *(MM/DD/YYYY)*: ……..……..

* *indicated as measles or MMR vaccines in the vaccination card / immunization records*

Have you suffered from **Rubella (German measles)**?

❑ No ❑ Yes - Date *(MM/DD/YYYY)*: ……..

Have you been vaccinated against **Rubella (German measles)**?

❑ No ❑ Yes - Dates of vaccinations* *(MM/DD/YYYY)*: ……..……..

* *indicated as MMR vaccines in the vaccination card / immunization records*

Have you suffered from **Varicella (chickenpox)**?

❑ No ❑ Yes - Date *(MM/DD/YYYY)*: ……..

Have you been vaccinated against **Varicella (chickenpox)**?

❑ No ❑ Yes - Dates of vaccinations *(MM/DD/YYYY)*: ……..……..

Have you suffered from **coronavirus infection (COVID-19 disease)** ?

❑ No ❑ Yes - Date *(MM/DD/YYYY)*: ……..

Have you been vaccinated against **coronavirus (Sars-CoV-2)**?

❑ No ❑ Yes - Name of vaccine: ……..……..

Dates of vaccinations *(MM/DD/YYYY)*::……

Vaccination is compulsory for students partaking in clinical practices*, therefore it is highly recommended that prospective students are vaccinated against coronavirus in their country of residence / before their arrival to Szeged, Hungary !*
Vaccination Certificate must be attached!

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. CHECKLIST OF MEDICAL TESTS:

The University of Szeged, Albert Szent-Györgyi Medical School/ Faculty of Dentistry/Pharmacy/Health Sciences and Social Studies requires the following medical documents after acceptance as attachments of this form **in a closed envelope**:

❑ **The following three serological tests for Hepatitis B:**

1. **Hepatitis B surface antigen (HBsAg) blood test** (paper-based result)
2. **Hepatitis-B surface antibody blood test (anti-HBs)**
   ≥10 mIU /ml is acceptable if under 10 mIU/ml a booster shot is needed) (paper-based result)
3. **Hepatitis-B core antibody (anti-HBc) blood test** (paper-based result)

❑ **Hepatitis B vaccination (3 shots required) proved by the copy of the Vaccination Card / Immunization Records**

❑ **Hepatitis C blood test** (paper-based result)

❑ **HIV blood test** (paper-based result)

❑ **Measles (morbilli) IgG antibody blood test** (laboratory evidence of measles immunity)
In lack of immunity one shot of MMR vaccine is needed (copy of the vaccination certificate must be attached)

❑ **Copy of your Vaccination Card* or Immunization Records* (incl. childhood vaccinations) issued by your GP**

❑ **Copy of your Coronavirus Vaccination Certificate** (must contain the details of all doses received)

❑ **Chest X-ray (Paper-based English language written result** is required. CD/X-ray film is NOT needed.)

❑ **Paper-based result of BLOOD test** (glucose; liver function: AST, ALT, GGT, ALP, bilirubin; renal function: creatinine, BUN; complete blood count with differential) **and URINEANALYSIS result**

The above listed documents and medical test results must be in ENGLISH language with the student's NAME (in Latin alphabet) and the DATE of the examination (acc. to Gregorian Calendar) displayed, stamped and signed by the physician who issued them. Failing to submit the required medical documents you might be banned from registration.

PLEASE NOTE: medical tests have to be taken after January 1, 2022.

III. SUMMARY OF MEDICAL TEST RESULTS

(TO BE FILLED IN BY THE APPLICANT'S GENERAL PRACTITIONER / FAMILY PHYSICIAN)

	Result / Evaluation:	**Date of test:** *(MM/DD/YY)*	**Physician's Comment:**
Chest X-ray			
Blood Test *(CBC, LF, RF, Gluc)* **& Urinalysis**			
Hepatitis B surface Antigen (HBsAg)	*negative / positive*		
Hepatitis B core Antibodies (anti-HBc / HBc Ab)	*negative / positive*		
Hepatitis B surface Antibody (anti-HBs / HBs Ab)	Antibody titre: ..... mIU/ml *immune / *non-immune*		**If not immune, date of* ***booster vaccination:*** .....
Hepatitis C Antibodies (HCV Ab)	*negative / positive*		
HIV Antigens, Antibodies (HIV Ag/Ab)	*negative / positive*		
Measles *(morbilli)* IgG antibodies *TEST METHOD? ELISA / EIA / HAI / AI / CLIA*	Antibody titre: ..... *Unit:*..... *immune / *non-immune*		**If not immune, date of* ***booster vaccination:*** .....

Please attach the English language copies of the original medical test results.

IV. DECLARATION OF THE GENERAL PRACTITIONER / FAMILY PHYSICIAN

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: ……. …… *(MM/DD/YYYY)*

SIGNATURE: …….....
(*+ REGISTRATION NUMBER OF THE DOCTOR)*

STAMP: