

Certificate of Health

Name in full: _____ Age: _____
(Family name) (First name)

Address: _____

I. History (Injury, illness or operation during the past five years)

Injury or illness:

Operation:

II. Examination:

Height: _____ cm Weight: _____ kg

Check for normal:

- | | |
|---|-----------------------------------|
| <input type="checkbox"/> Head | <input type="checkbox"/> Eyes |
| <input type="checkbox"/> Ears | <input type="checkbox"/> Nose |
| <input type="checkbox"/> Pharynx | <input type="checkbox"/> Neck |
| <input type="checkbox"/> Heart | <input type="checkbox"/> Lungs |
| <input type="checkbox"/> Abdomen | <input type="checkbox"/> Reflexes |
| <input type="checkbox"/> Mental Condition | |

Describe abnormalities: _____

III. Summary:

In my opinion the applicant's health condition is:

I believe this applicant (is / is not) physically and mentally able to study abroad.

Remarks: _____

Signature: _____

Address: _____

Date: _____