*\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Dept, year \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_*

 *Change status \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_*

 *Dormitory \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_*

*\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_*

*Please, fill out all the lines on this form and submit it to the AUCA Medical Office*

*together with original medical documents mentioned in the List of medical documents*

**Student’s Health Background Form**

1. **Personal data**

\*Please, write data exactly as it appears on your personal ID (passport)

First name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Last name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Patronymic: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Attach photo 3x4

Date of birth: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Citizenship: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Personal ID (passport) #: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Sex: Male / Female

Mobile phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

E-mail: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Academic program (underline):

NGA Undergraduate Graduate Exchange student Visiting Student

Department: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Contact person**

Please write the contact information about a family member or tutor, who should be contacted in an emergency situation:

First name, last name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Relation to student: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Phone (including codes of country and city): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

E-mail: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Additional contact information (another family member / close relative):**

First name, last name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Relation to student: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Phone (including codes of country and city): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

1. **Medical information**

*All medical information is in strict confidence.*

* 1. **Immunization records \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

Submit information about immunization (according analogous form #063 in Kyrgyz Republic). Mark Yes/No/I don’t know[[1]](#footnote-1)

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| 1 | Measles | Yes | No | I don’t know |
| 2 | Parotitis (mumps) | Yes | No | I don’t know |
| 3 | Rubella | Yes | No | I don’t know |
| 4 | Viral hepatitis B | Yes | No | I don’t know |
| 5 | Pertussis | Yes | No | I don’t know |
| 6 | Diphtheria | Yes | No | I don’t know |
| 7 | Tetanus | Yes | No | I don’t know |

* 1. **Indicate the health issues that affect you**

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| 1 | Allergy to medications (write what medicaments cause allergy and reactions in detail in the “Notes” section) | Yes | No | I don’t know |
| 2 | Allergy for stings of insect or some food (write causes and reactions in detail in section “Notes”) | Yes | No | I don’t know |
| 3 | Pollinosis, nettle rash, seasonal allergies | Yes | No | I don’t know |
| 4 | Asthma | Yes | No | I don’t know |
| 5 | Vision loss, hearing loss (blindness, deafness) | Yes | No | I don’t know |
| 6 | High arterial pressure | Yes | No | I don’t know |
| 7 | Migraine, headaches | Yes | No | I don’t know |
| 8 | Brain concussion | Yes | No | I don’t know |
| 9 | Epilepsy | Yes | No | I don’t know |
| 10 | Depression | Yes | No | I don’t know |
| 11 | Psychological illness (write in detail in section “Notes”) | Yes | No | I don’t know |
| 12 | Drug abuse | Yes | No | I don’t know |
| 13 | Cardiac (heart) diseases (write in detail in section “Notes” – name, date of disease) | Yes | No | I don’t know |
| 14 | Diabetes | Yes | No | I don’t know |
| 15 | Thyroid gland diseases or other endocrine diseases | Yes | No | I don’t know |
| 16 | Hepatitis A | Yes | No | I don’t know |
| 17 | Hepatitis B | Yes | No | I don’t know |
| 18 | Hepatitis C | Yes | No | I don’t know |
| 19 | Digestive disorders | Yes | No | I don’t know |
| 20 | Colitis, irritable bowel syndrome (IBS), or Crohn’s disease | Yes | No | I don’t know |
| 21 | Kidney stones or kidney diseases | Yes | No | I don’t know |
| 22 | Dermatological problems | Yes | No | I don’t know |
| 23 | Shingles | Yes | No | I don’t know |
| 24 | Have you undergone a surgical operation (if yes, do you have metallic implants? Write in detail in the section “Notes.” (please include operation name and date)) | Yes | No | I don’t know |
| 25 | Menstrual irregularities (**for girls**!) | Yes | No | I don’t know |
| 26 | Other diseases (Write in detail in section “Notes” (disease name, date)) | Yes | No | I don’t know |

* 1. Notes (if space is not enough, use separate paper) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
	2. Please, enumerate medication you take on regular basis (write dosage, times per day) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

I, \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_, confirm that aforementioned information submitted by myself is correct, and I assume full responsibility for false medical data.

Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

1. Please, remember, that non-vaccinated students bear full liability in case of being infected with the disease. [↑](#footnote-ref-1)