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

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

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

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

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

*together with original medical documents mentioned on the Page 4.*

**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 details in section “Notes”) | Yes | No | I don’t know |
| 12 | Drug abuse | Yes | No | I don’t know |
| 13 | Cardiac (heart) diseases (write in details 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 surgical operation (if yes, do you have metallic implants? Write in details in section “Notes”  (please include operation name, date)) | Yes | No | I don’t know |
| 25 | Menstrual irregularities (**for girls!**) | Yes | No | I don’t know |
| 26 | Other diseases (Write in details 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;

□ **undertake to annually purchase and submit to the AUCA Medical Office a Compulsory Health Insurance Policy (CHI policy) in accordance with the Law of the Kyrgyz Republic dated 18.10.199 №112 "On Medical Insurance of Citizens in the Kyrgyz Republic" (for foreign students).**

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

**List of medical documents**

Medical documents meeting following requirements are to be submitted in Kyrgyz, Russian or English languages. If document is written in another language, a translation of the document must be attached and notarized in accordance with the legislation of KR. Original copies of the reports must be attested with a seal of the medical institution, a seal and a signature by the doctor or a laboratory’s seal.

Medical documents must be submitted to the AUCA Medical Office.

**Health certificates:**

1. Vaccination information (similar to the **#063-form** in Kyrgyz Republic) – original and photocopy.

1. **Tuberculosis**

The examination must include: a fluorography, OR X-ray radiograph, OR computed X-ray tomography (CT scan) for chest organs, ***made not later than 6 months prior to the submission of the documents to AUCA***. Imaging, its description, and medical report (originals) **must be submitted.**

*If Medical Office will have any questions about medical description or translation, it can request a retest.*

1. **HIV/AIDS**

Medical report (original of the test result) on the basis of blood analysis, made ***not later than 1 month prior to submission of documents to AUCA***.

1. **Malaria**

Medical report (original of the test result) on the basis of blood analysis for malaria (a thick blood smear method), made ***not later than 1 month prior to submission of documents to AUCA.***

1. **Viral hepatitis B**

In case of absence of vaccination information (similar to the #063-form in Kyrgyz Republic), please submit medical report (original of the test result) on the basis of blood analysis for marker of viral hepatitis B – **HbsAg**, made ***not later than 1 month prior to submission of documents to AUCA.***

1. **Measles and Rubella**

**In case of an absence of information about a vaccination**, (similar to the #063-form in Kyrgyz Republic) (see **Information about student’s health status**), please submit a medical report on the basis of blood analysis for markers IgG and IgM for Measles and Rubella.

***ATTENTION:***

***-*** *if you submit information about vaccination against* ***measles, rubella, and viral hepatitis B***(similar to the **#063-form** in Kyrgyz Republic), *you are EXEMPTED from undergoing blood tests for diseases aforementioned on the Paragraphs 6 and 7!*

*-* ***All International students must purchase and submit to the AUCA Medical Office a Compulsory Health Insurance Policy (CHI policy) upon arrival in Kyrgyzstan and annually thereafter, in accordance with the Law of the Kyrgyz Republic dated 18.10.199 №112 "On Medical Insurance of Citizens in the Kyrgyz Republic".***

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