HEALTH DECLARATION FORM

ENGLISH LANGUAGE HEALTH SCIENCE PROGRAMMES

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)*

PLACE OF BIRTH (CITY, COUNTRY): ……………………………DATE OF BIRTH *(MM/DD/YYYY)*: ………………….

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

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 (infectious/non-infectious diseases): **No / Yes** *(if 'yes, please list)*:

……………………………………...……………………………

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** *(if ' yes' please list):*

..…………………………………...………………………………………………………………………………

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** *(if 'yes' please list):*

…….

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** *(if 'yes' please list):* …………………………………………………..……………………………………….………...

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/rubeola)**?
❑ No ❑ Yes - Date *(MM/DD/YYYY)*: ……………………………………………………
Have you been vaccinated against **Morbilli (measles/rubeola)**?
❑ 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)*: ……………………………………………………

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/Faculty of Pharmacy/Health Sciences and Social Studies requires the following medical documents after acceptance as attachments of this form **in a closed envelope**:

❑ **Chest X-ray (Paper-based English language written result** is required. CD/X-ray film is NOT needed.) ***OR*** a paper-based negative result of **TB blood test (IGRA /interferon-gamma release assay/)**

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

❑ **Copy of your Vaccination Card* or Immunization Records* (incl. childhood vaccinations)** An official English translation of the original document or an English language transcript issued and verified by your GP can be accepted. The vaccination documents must certify that you have been vaccinated against **Hepatitis B** and **measles** (rubeola or morbilli), containing a full vaccination series for Hepatitis B (2 or 3 doses at least, depending on vaccine type) and 2 doses for measles (usually in form of MMR vaccines).

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

1. **Hepatitis B surface antigen (HBsAg) blood test** (paper-based laboratory result)
2. **Hepatitis-B core antibody (anti-HBc) blood test** (paper-based laboratory result)
3. **Hepatitis-B surface antibody (anti-HBs) blood test** (paper-based result) = Hepatitis B immunity test

An antibody titre of **≥10.0 mIU /ml** is required as proof of immunity! If the antibody titre is **under 10.0 mIU/ml,** a **Hepatitis B booster vaccination** is needed (the vaccination certificate must be attached!) and the antibody titre must to be checked again 4-6 weeks after the booster vaccination (the follow-up anti-HBs result must be enclosed).

❑ **Hepatitis C blood test** (anti-HCV; paper-based laboratory result)

❑ **HIV blood test** (HIV Ag & Ab, paper-based laboratory result)

❑ **Measles (morbilli/rubeola) 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)

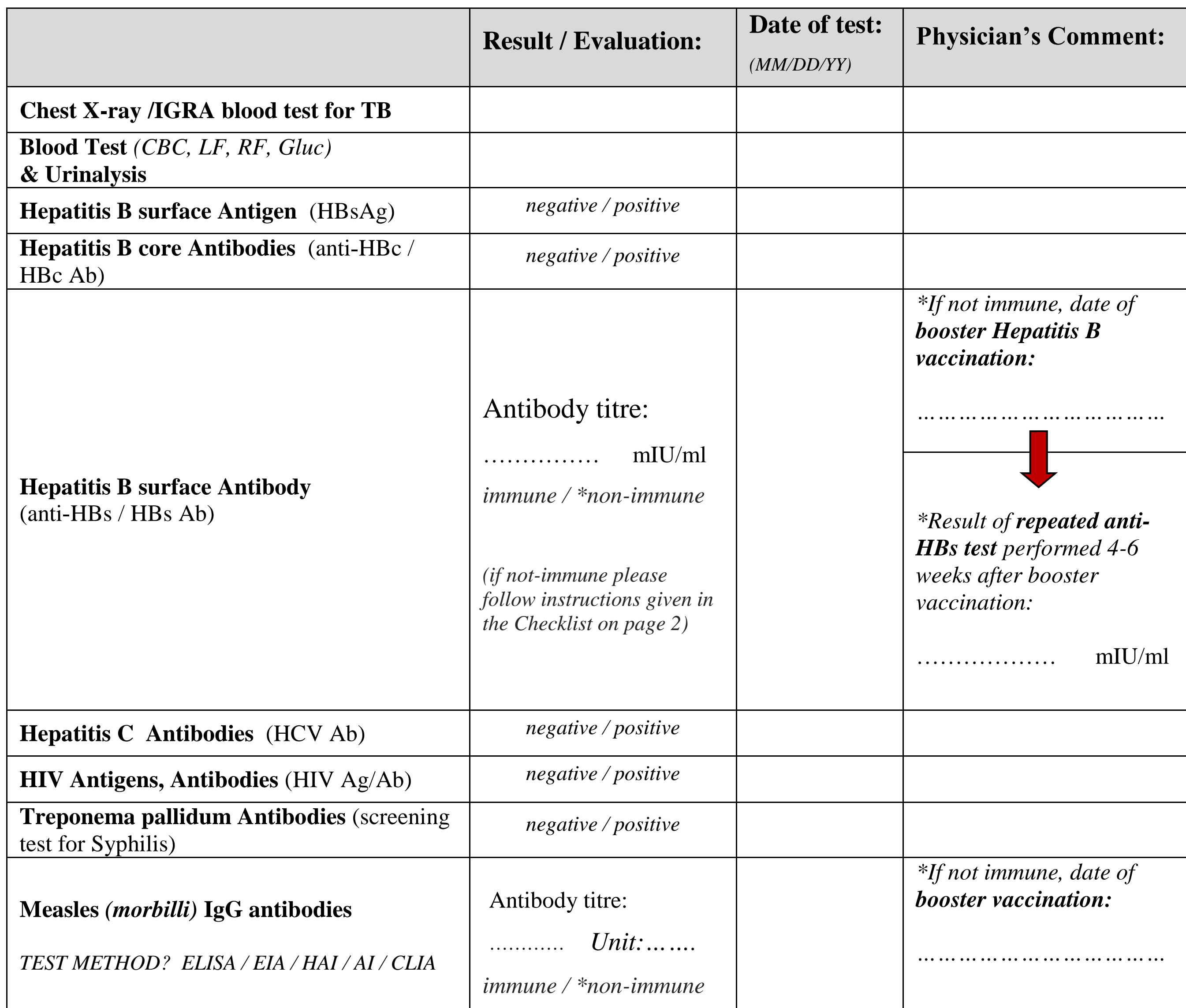
❑ **Treponema pallidum antibodies** (screening blood test for Syphilis - paper-based laboratory result)

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, 2025.

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 /IGRA blood test for TB			
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 please follow instructions given in the Checklist on page 2)*		**If not immune, date of* ***booster Hepatitis B vaccination:*** ……………………………… **Result of* ***repeated anti-HBs test*** *performed 4-6 weeks after booster vaccination:* ……………… mIU/ml
Hepatitis C Antibodies (HCV Ab)	*negative / positive*		
HIV Antigens, Antibodies (HIV Ag/Ab)	*negative / positive*		
Treponema pallidum Antibodies (screening test for Syphilis)	*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: