STUDENT´S MEDICAL HISTORY

This medical history form must be completed in order to enroll in classes. Personal medical history is required of all students. All information is considered confidential.

To be completed by student:

Applicant: _____

(First name) (Middle name) (Surname)

Date of Birth (Month/Day/Year):_____

Parent(s) or Guardian: _____

Parents or Permanent Address (if different than above):_____

(Number & Street)

_____Telephone Number:_____

(City/State or Province/Postal Code/Country)

Email Address: _____

PERMISSION FOR DIAGNOSTIC AND TREATMENT PROCEDURES:

I hereby authorize the physicians at area hospitals to perform diagnostic and treatment procedures on the students named above, which in their judment may become necessary while he/she is at Universidade Federal de Goiás. I waive all claim to prior notification. I understand that if in the judment of the professional staff, the student´s parents or guardian should be notified, this will be done.

Signature of Parent/Guardian:_____Date:_____/____/____

Parent/Guardian Signature Month Day Year

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Personal Medical History

Check the box if you have had the disease listed:

( ) Chicken Pox	( ) Diphtheria	( ) Measles
( ) Mumps	( ) Polio	( ) Rheumatism
( ) Scarlet Fever	( ) Tuberculosis	( ) Whooping Cough
( ) Yellow Fever	( ) Malaria	( ) Smallpox
( )Typhoid Fever	( )BCG (TB skin test required)	( ) Hepatitis

Special Concerns – check and respond as appropriate:

( ) Asthma	( ) Auditory	( ) Cerebral palsy
( ) Diabetes	( ) Epilepsy	( ) Heart
( ) Kidney	( ) Ulcers	( ) Visual
( ) Wheel chair	( ) Other _____	

( ) Allergies (specify)_____

( ) Injuries (specify) _____

( ) Surgery (specify) _____

( ) Family illness (specify) _____

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To be completed by physician

Student´s Name: _____Date of Birth:_____

(Month/Day/Year)

Medication Allergies: _____

Vaccinations (include dates administered and attach copy of immunization record

Measles (required if born in or after 1957) First dose: _____ Second dose (required):_____ Diphtheria: _____ Oral Polio – required: _____ Tetanus (required within five years):	Tuberculosis Test Results (required)*:_____ (results in millimeters) Name of Test: _____ Date of Test: _____ or Chest-X Ray reading: _____ *Test must have been administered and results verified by either physician or Health Department within the twelve months preceding enrollment at UFG.

Physician´s Assessment				**List Current Medications:**
Subjects	**Normal**	**Abnormal**	**Comments**	
Eyes				
Vision				
Ears				
Nose				
Tonsils				
Teeth				
Thyroid				
Cervical Glands				
Breast				
Lungs				
Heart				
Abdomen				
Skin				
Extremities				
Hemoglobin				
Blood Pressure				
Other Physical Defects				

Any restriction on physical activity? ( ) Yes ( ) No

If yes, please explain and recommend any permitted activity: _____

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How long have you known the student? _____

Most recent examination: _____

Other health-related recommendations or restrictions: _____

On the basis of your examination and knowledge, do you believe the student is physically and emotionally able to participate in a full program of college-level study and related activities?

( ) Yes ( ) No

Any other comments:

_____

_____

_____

Doctor´s full name: _____

Address:_____

_____

_____

Office Telephone: _____

Doctor´s Signature: _____ **Date:** _____

Student`s Signature: _____ **Date:**_____

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