

APPLICATION FOR ADMISSION TO AN EDUCATIONAL INSTITUTION
IN THE UNITED STATES OF AMERICA

CERTIFICATE OF HEALTH

Applicant's Name _____ Age _____ Male _____ OR Female _____

Applicant's Address _____
Street Number and Name *City or Town* *Country*

IMPORTANT: All immunizations must be current for diphtheria, tetanus, measles, and mumps. Y.C.C.D. requires an Original Certification (not a copy) of your Tuberculosis Test results from your doctor showing you have had a tuberculosis test within the year—it can be either a chest x-ray or skin test.

1. This section to be completed (in English) and signed by STUDENT before visiting the physician.

A. Have you, to the best of your knowledge, ever had any of the following? If yes, please mark (X).

___ Hernia	___ Cholera	___ Sexually	___ Abnormal	___ Stomach
___ Sinusitis	___ Measles	Transmitted Disease	Blood Pressure	Disorder
___ Allergies	___ Diabetes	___ Mental/Emotional	___ Heart Disease or	___ Arthritis
___ Asthma	___ Typhoid	Disorder	Disorder	___ Sciatica
___ Goiter	___ Paralysis	___ Disease of Nervous	___ Disease or Disorder	___ Rheumatism
___ Cancer	___ Pneumonia	System	of the Back or Spine	___ Rectal Disease
___ Malaria	___ Appendicitis	___ Rheumatic Fever	___ Disease of Kidneys or	or Disorder
___ Gall Bladder	___ Tuberculosis	___ Disease of Eyes	Genito-Urinary System	___ Intestinal
Disorder	___ Prostate Disease	___ Disease of Ears	___ Mumps	Disorder

If you marked any of the above, give nature, date, period of disability and result _____

B. When and for what injury or sickness have you been under observation or had medical or surgical advice or treatment or been confined to a hospital during the past five years? _____

C. To the best of your knowledge and belief, are you now in good health and free from physical impairments? ___ Yes or No ___
If not, explain _____

Signature of Applicant _____ Date _____

2. THIS SECTION IS TO BE COMPLETED BY A PHYSICIAN (in English), signed and returned to student with an Original Certificate of Tuberculosis Test Results.

A. **PHYSICAL EXAMINATION.** List height and weight, check abnormalities and describe in detail under "Remarks."

___ Height	___ Nose	___ Pharynx	___ Reflexes
___ Weight	___ Eyes	___ Neck	___ Heart
___ Head	___ Ears	___ Hernia	___ Abdomen

B. **TUBERCULOSIS TEST MUST BE ADMINISTERED.** *Original Certificate of Tuberculosis Test must be provided with this form.*

Please comment in full on the condition of the Applicant's lungs _____

C. Do you believe the applicant is physically able to carry on a full course of study in a college or university? ___ Yes ___ No

D. In your opinion, the applicant's health and physical condition is ___ EXCELLENT ___ GOOD ___ FAIR ___ POOR

The applicant presents no evidence of communicable disease, over-fatigue, or physical defect unless stated below.

E. **REMARKS:** _____

Signature of Physician _____ Date _____

Printed Name of Physician _____ License Number _____

Physician's Address _____