

HEALTH CERTIFICATE FORM

STUDENT INFORMATION

Last Name _____ First Name _____ Middle Name _____

Age _____ Sex M F Date Examined _____

MEDICAL INFORMATION

(to be completed by a physician)

Have you examined the applicant for any illness? Y N

If so, explain _____

Has the applicant been treated for any of the following?

- Tuberculosis Diabetes Heart disease Anemia Migraine
 Asthma Rheumatic Fever Epilepsy Thyroid Disorders

If so, explain _____

Does the applicant have any handicap, which may interfere with his/her studies? Y N

If so, explain _____

Has the applicant received treatment or been admitted to a hospital for mental disorders? Y N

If so, explain _____

Does the applicant have any abnormalities in the following?

- Skin Lymph nodes Heart Ears Nose & Sinus Chest
 Spine Head Abdomen Vascular System Endocrine System
 Neurological System

If so, explain _____

VITAL SIGNS

Temperature

Blood Pressure

Pulse

Breathing

Does the applicant have any vision problems?

 Y N

If so, explain _____

Has the applicant received all immunizations?

 Y N

After examining the applicant, do you find him/her fit for any form of mental and/or physical activity?

 Y N

PHYSICIAN INFORMATION

Name _____

Address _____

Telephone (please include area code) _____

Signature and Stamp

Date

Please note this form is not valid without the Doctor's stamp

Instructions

Please, mail this form with the application for admission form and all other required documents to:

UNIVERSIDAD DE IBEROAMERICA COSTA RICA
Att: Silvia Monzon
P.O. BOX 144880
CORAL GABLES, FL 33114-4880