RHEINISCHE FRIEDRICH-WILHELMS-UNIVERSITÄT BONN
Dezernat für Internationale Angelegenheiten / *International Office*

universitätbonn

Gesundheitszeugnis / *Health Certificate*

Name, Vorname / *name, first name*: _____

Geburtsdatum / *date of birth*: _____

Nationalität / *nationality*: _____

Heimathochschule / *home university*: _____

Dieses Formular soll uns helfen, Ihnen während Ihres Aufenthaltes in Bonn im Notfall helfen zu können. Daher ist es wichtig, dass Sie uns auf medizinische oder psychische Probleme aufmerksam machen, damit wir angemessen reagieren können. Die angegebenen Informationen werden vertraulich behandelt. **Sie beeinflusst nicht die Aufnahme in das Programm.**
This form will help us to provide you with the necessary medical support you may need during your stay in Bonn. It is necessary that we be made aware of any medical or emotional problems which might affect you during your stay. The provided information will be treated as confidential and will only be shared with the International Office staff. ***This information will not affect your admission into the Program***

TO BE COMPLETED BY THE PHYSICIAN:

Does the above-named person have or has he/she had any disease or condition requiring medication, regular physician's care, surgery or other treatment? If yes, please state below:

_____

Has the patient ever sought professional help for a psychiatric or emotional problem? If yes, please explain

_____

Does he/she take any medication(s) on a regular basis? If yes, please state below:

_____

Does he/she have any of the following? If yes, please explain type and severity:

Medication allergies	No	Yes _____
Food allergies	No	Yes _____
Other allergies	No	Yes _____
Asthma	No	Yes _____
Diabetes	No	Yes _____
Epilepsy	No	Yes _____

Immunization record –
DPT
Tetanus
Hepatitus A
Hepatitus B

Do you consider the patient to be in adequate mental and physical health for full and successful participation in the study abroad program?

_____

Name and Address of Physician: _____

Physician's signature: _____