



UNIVERSIDAD IBEROAMERICANA
- UNIBE -
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 Migrane Asthma

Rheumatic Fever Epilepsy Thyroid Disorders

If so, explain _____

Does the applicant have any handicap wich 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 Lymphonodes Head Ears Nose & Sinus Spine Chest

Heart 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, did you find any significant medical condition or disability that would limit his/her participation in academic and/or physical activities? If so, please specify:

Y N _____

PHYSICIAN INFORMATION

Name _____

Address _____

Telephone (please include Area Code) _____

Signature and Seal/Stamp*

Date

*Please note this form is not valid without the Doctor's Seal/Stamp

INSTRUCTIONS

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

UNIBE
P.O.BOX 770937
MIAMI, FL 33177