



Physician's Medical Statement  
**Central European University**  
 in Budapest, Hungary

This statement is to be completed by the applicant's physician.

**TO THE PHYSICIAN:** In evaluating the Applicant, please consider evidence of irritability, headaches, insomnia, depression, allergies, asthma, and other disorders, such as diabetes. Attach an extra page if necessary. Please type or print neatly in black ink.

Applicant's name \_\_\_\_\_ Date of birth \_\_\_\_\_  
(month/day/year)

**IMMUNIZATION RECORD**

MMR Immunization dates \_\_\_\_/\_\_\_\_/\_\_\_\_; \_\_\_\_/\_\_\_\_/\_\_\_\_

Measles (rubeola) Immunization dates \_\_\_\_/\_\_\_\_/\_\_\_\_;

\_\_\_\_/\_\_\_\_/\_\_\_\_

or date of disease \_\_\_\_/\_\_\_\_/\_\_\_\_;

or measles titer \_\_\_\_/\_\_\_\_/\_\_\_\_

Rubella Immunization date \_\_\_\_/\_\_\_\_/\_\_\_\_

or rubella titer \_\_\_\_/\_\_\_\_/\_\_\_\_

Mumps Immunization dates \_\_\_\_/\_\_\_\_/\_\_\_\_;

or date of disease \_\_\_\_/\_\_\_\_/\_\_\_\_;

or mumps titer \_\_\_\_/\_\_\_\_/\_\_\_\_

Last DT booster \_\_\_\_/\_\_\_\_/\_\_\_\_

Polio Ser. Comp. \_\_\_\_/\_\_\_\_/\_\_\_\_

PPD \_\_\_\_/\_\_\_\_/\_\_\_\_ | negative | positive

Chest X ray \_\_\_\_/\_\_\_\_/\_\_\_\_ | negative | positive

**Note:** The health service requires that all students undergo a PPD skin test. In the presence of PPD reaction measuring 10 mm x 10 mm diameter or greater duration, a chest X ray is required.

**VACCINATION DEFICIENCIES**

**Measles (rubeola)**

\_\_Vaccination not documented

\_\_Two-dose vaccination not documented

\_\_Vaccinated before 1968

\_\_Vaccinated prior to 12 months of age

**Rubella**

\_\_Vaccination not documented

\_\_Vaccinated before 1968

\_\_Vaccinated prior to 12 months of age

\_\_Titer result not given

**Mumps**

\_\_Vaccination not documented

\_\_Vaccinated prior to 12 months of age

\_\_Titer result not given

**Disease, Operation, or Injury Record**

**Period of Disability**

_____	From	_____	To
_____	From	_____	To

I have examined \_\_\_\_\_ and believe that this individual is physically and mentally qualified to study abroad. This individual is free from tuberculosis and presents no evidence of communicable disease, over fatigue, or any other condition that would impair participation in a study-abroad program.

Name of physician \_\_\_\_\_

Address \_\_\_\_\_

I certify that all information in this application is complete and accurate. Date \_\_\_\_\_

**Study Abroad at Central European University**

PO BOX 6216, Astoria, New York, NY 11106

Tel: 845-758-7875 Fax: 347-730-6813 or 845-758-7040 E-Mail: ceu@bard.edu Web: http://ceu.bard.edu