

# MEDICAL INFORMATION SHEET

***To ensure medical secrecy, please kindly place this questionnaire in a sealed envelope for the attention of the nurse of the UTT. Please kindly write your contact details on the envelope.***

***Please do not hesitate to contact the health service (doctor or nurse) of the UTT either at the start of or during the Academic Year to let them know any health problem which might affect your studies.***

***Please kindly note that you must take your health record book when going to your UTT medical checkup as you will be requested to submit this document on this occasion.***

***Medical checkup for minor students: Beware, we will contact your family in case of two unattended UTT medical checkups.***

**SURNAME:** \_\_\_\_\_ **Given name :** \_\_\_\_\_

Born (DD/MM/YY): \_\_\_\_\_

In (place) : \_\_\_\_\_

Age: \_\_\_\_\_

Sex:  M  F

“Département”: (applies if you were born in France) \_\_\_\_\_

Country: \_\_\_\_\_ Nationality: \_\_\_\_\_

Parents' address: \_\_\_\_\_

Students' address: \_\_\_\_\_

Parents' phone number: \_\_\_\_\_ Student's phone number: \_\_\_\_\_

Social security number: \_\_\_\_\_

Emergency contact person (title, name, phone number): \_\_\_\_\_

▶ **Do you suffer from one of the following diseases?**

- |  |                              |                             |                        |
|--|------------------------------|-----------------------------|------------------------|
| - Allergy  | <input type="checkbox"/> Yes | <input type="checkbox"/> No | If yes, to what: _____ |
| - Asthma   | <input type="checkbox"/> Yes | <input type="checkbox"/> No |                        |
| - Diabetes   | <input type="checkbox"/> Yes | <input type="checkbox"/> No |                        |
| - Epilepsy   | <input type="checkbox"/> Yes | <input type="checkbox"/> No |                        |
| - Dyslexia, dyscalculation, dys-spelling, dyspraxia... | <input type="checkbox"/> Yes | <input type="checkbox"/> No |                        |
| - Psychiatric disorders                                | <input type="checkbox"/> Yes | <input type="checkbox"/> No |                        |
- Other chronic disease or handicap, please specify: \_\_\_\_\_

▶ **Do you take/receive regular medical treatment?**  Yes  No

If yes, please specify : \_\_\_\_\_

***You may leave the medicine(s) corresponding to your treatment(s) and a copy of the related medical prescription at the sick bay of the UTT to be able to face emergency situations.***

▶ **Date of your last admission to hospital and cause of admission:** \_\_\_\_\_

▶ **Your education:**

Have special arrangements already been made in order for you to be able to attend school/courses?

Yes  No

Have you ever taken an examination under special conditions? (additional exam time, special arrangements, others)

Yes  No

If yes, please specify: \_\_\_\_\_

**Filled out in (place):**

**Date, (DD/MM/YY):**

**Student's signature (or of his legal representative if minor)**