Health & Medical Clearance Form

Please answer the questions below. The information you provide is strictly confidential and will be used only for the admission process and the assistance with your healthcare during your stay at Ajou University as an enrolled student. **This form must be signed by a licensed health professional**. If any medical records are not in English, please provide translation. Please upload this form when you submit the online application.

Student Information					
Last Name		Date of Birth (YYYY/MM/DD)		Gender	M / F
First Name					

I agree that the below information is true and give permission to Ajou University and related health care services to share all of my medical information, if necessary, in order to coordinate my medical care in the event of emergency while I am at Ajou University. I understand that admission can be re-considered if I have health problems unsuitable for studying abroad, and I can be asked for further health check-up and appropriate treatment if needed.

Date: _____ Student's Name: _____ (Signature)

The section below must be filled out by the doctor or physician	**Yes/No**
1. What is the result of his/her tuberculosis test result? Date of TB testing (YYYY/MM/DD): Date of TB result reading (YYYY/MM/DD): Result of TB test: *** Tuberculosis test: Chest X-ray, TB skin test, and etc.** *** The test should be done within 3 months at the time of submitting this form.**	
2. Does he/she have any allergies to medication, food, animals, and etc.?	
3. Does he/she have any dietary restrictions?	
4. Does he/she currently receiving any treatment or prescribed medication on a regular basis?	
5. Have he/she had any serious ailment, injuries or diseases in the last five years?	
6. Have he/she had a major surgical operation, been advised to have one, or hospitalized?	
7. Have he/she ever been treated by doctor for any mental, emotional, anxiety, or nervous disorder?	
8. If there are any special note to applicant's health condition, please describe, in as much detail as possible. (For allergies, please indicate what this applicant is allergic to, and etc.)	

If there are any additional explanation or medical documents (such as TB result) are to be submitted, please attach separate note.

Verification from doctor/physician/health professional (additional stamp if needed)

Physician's Name			
Date (YYYY/MM/DD)		Signature	