



**The Hebrew University of Jerusalem**

The Robert H. Smith Faculty of Agriculture, Food & Environment

The Division for External Studies

## M.Sc. MEDICAL STATEMENT

<b>First name:</b>	<b>Family name:</b>
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This form is to be completed by the applicant.

The Hebrew University reserves the right to require the applicant to undergo a further medical examination before or during the period of studies.

If the answer to a question is yes, please give dates in the box on the right and explain on a separate page.

<b>Has any member of your family suffered from:</b>			
tuberculosis?	Yes	No	
mental illness?	Yes	No	
asthma?	Yes	No	
epilepsy?	Yes	No	
malaria?	Yes	No	
STD (sexually transmitted diseases), including HIV?	Yes	No	

<b>Have you suffered in the past or do you now suffer from problems related to:</b>			
Heart (cardiovascular), lung and/or respiratory system (TB, asthma, tumor, etc.)?	Yes	No	
Stomach, intestines, liver, kidney (nephritis, stones, etc.)?	Yes	No	
Nervous system (convulsions, stroke, mental illness, stress-related disorders, etc.)?	Yes	No	
Glandular system (such as goiter, diabetes, anemia)?	Yes	No	
Skin, muscles, bones, joints?	Yes	No	
Sensory organs (eyes, ears, etc.)?	Yes	No	
STD (sexually transmitted diseases), including HIV?	Yes	No	

I, the undersigned, understand and agree that the University reserves the right to take any necessary measures in connection with candidates who submit partial, incorrect and/or false information, and certify that all information given here is full and correct. I waive my right to privacy regarding all medical information and documentation relevant to processing my application for studies.

<b>Date (dd/mm/yy):</b>	<b>Signature:</b>
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