** KEMENTRIAN RISET, TEKNOLOGI, DAN PENDIDIKAN TINGGI**

**POLITEKNIK NEGERI MALANG**

**UNIT PELAKSANA TEKNIS (UPT) BAHASA**

Jalan Soekarno-Hatta 9, P.O. Box 04 Malang – 65141

Telepon (0341) 404424-404425 Pswt. 1050 Fax. (0341) 404420

**HEALTH INFORMATION FORM**

Thank you for your interest to have an academic experience at POLINEMA. It is important that we be aware of any past or current medical issues, including mental health conditions, which might affect your study. This information will be kept confidential to protect student privacy. Disclosure of such information may be made to appropriate individuals (including program staff and resident directors) and to provide you with assistance should the need arise during your study. Health tests, certifications, or other actions may also be required prior to departure in certain circumstances.

POLINEMA International Office is committed to enabling participation in POLINEMA programs for all qualified individuals. If you have questions, need assistance, or wish to discuss accommodations for health problems, please contact your buddy and/or the office. Accommodations may require extensive planning and communications with foreign contacts, so adequate lead time is critical. Contact should accordingly be initiated as soon as possible.

**PART A: GENERAL INSTRUCTIONS:**

Completing and having this is a condition of study in POLINEMA programs

Please complete this form in English either by typing or by hand, using black ink and in capital letters.

* You must notify POLINEMA IO of any relevant changes to the information that may occur prior to the program.
* The information in this form is confidential.
* Please take the signed original of this form plus any supporting documents.

**PART B: HEALTH HISTORY**

In case of hospitalization by POLINEMA, student’s medical records are available from:

|  |  |
| --- | --- |
| Physician / Hospital : |  |
| Telephone Number : |  |
| Address : |  |

Has the student ever had any infectious diseases?  No  Yes. If yes, please tick  any that apply:

|  |  |  |  |
| --- | --- | --- | --- |
|  Measles (Rubeola) |   Encephalitis |  Hepatitis (specify) |  Frequent tonsillitis |
|   Rubella (German measles) |   Pneumococcal infection |  Yellow fever |  Bronchitis |
|  Staphylococcal infection |   Streptococcal infection |  Other, please specify: |

Please provide a brief history/explanation regarding above and whether they have left any lasting complications:

Does the student have any recurring medical problems or chronic conditions?  No  Yes. If yes, please tick  any that apply:

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| Anemia/blood disorder | Eating disorder | HIV | Migraines/headaches |  |
| Asthma | Hypertension | Kidney disease | Mobility limitations |  |
| Autism/Asperger’s Syndrome | Diabetes | Learning disability | Tuberculosis |  |
| Lupus | Cardiovascular disease | Mental health concern | Color blind |  |
| Attention deficit hyperactivity disorder (ADHD/ADD) | Epilepsy | Other, please specify: |  |

Please specify if there is anything that POLINEMA staff should be aware of relating to any of the above:

**PART C: CURRENT MEDICATIONS AND NEEDS**

|  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- |
| Student’s Name: |  |  |  |  |  |  |  |
|  |  | *Last* |  | *First/Given* | *Middle* |  |  |
| Gender: **** Male |  | Date of Birth: | **\_\_ \_\_ \_\_ \_\_**  | **\_\_ \_\_ \_\_ \_\_**  | Country of Citizenship: |  |  |
|  **** Female |  |  |  |  |  |
|  |  |  |  *dd* | *mm* |  |  *Yyyy* |  |  |  |
|  |  |  |  |  |  |  |
| Department/Degree: |  |  | Duration of program (start date and end date): |  |
|  |  |  |  |  |  | Start date: | End date: |  |  |
|  |  |  |  |  |  |  |  |
|  |  |  |  |  |  |  |  |
| In case of emergency, please contact: |  |  |  | Language(s) spoken: |  |  |  |
|  |  |  |  |  |  |  |  |  |
| Contact number (Home): |  |  |  |  |  | Contact number (Office and/or Mobile): |  |  |
|  |  |  |  |  |  |  |  |  |
| *country code* | *Area code* | *number* |  |  | *country code* | *area code* | *number* |  |
|  |  |  |  |  |  |  |  |  |  |

**Diet**

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
|  | Do you require a special diet? | Yes  No  |  |  |  |
|  | If yes, please give details: |  |  |  |  |
|  | Are there any foods that you | Yes  No  |  |  |  |
|  | cannot or should not eat? |  |  |  |
|  |  |  |  |  |
|  |  |  |  |  |  |
|  | If yes, please give details: |  |  |  |  |
| **Allergies** |  |  |  |  |
|  |  |  |  |
|  | Do you have allergies to: |  |  |  |  |
|  | Food | Yes  No  | If yes, please specify: |  |  |
|  | Medicines | Yes  No  | If yes, please specify: |  |  |
|  | Others | Yes  No  | If yes, please specify: |  |  |
|  | What medications can you be given for an allergic reaction? |  |  |  |

**Medications**

Do you take any medications?\*)\*\*)

|  |  |  |  |
| --- | --- | --- | --- |
| Brand Name | Generic Name | Dose, Schedule, Special Instruction | If it is a prescription, is it renewable? |
|  |  |  | Yes No  |
|  |  |  | Yes No  |
|  |  |  | Yes No  |

*\*)Please ensure sufficient supply for the study’s duration.*

**Special Needs**

|  |  |  |  |
| --- | --- | --- | --- |
| Do you have any special needs or require any specific  Yes  No support? |  |  |  |
|  |  |

If yes, please specify:

*\*\*) Bringing any specific medical documentation would be very helpful for a doctor in the host country. Bringing it with you can help avoid unnecessary and expensive procedures. It is recommended that you discuss this with your regular physician.*

**PART D: HEALTH INSURANCE**

Are you holding health insurance? No  Yes 

**If no**, it is strongly recommended that you make your own health insurance. If you are not going to have health insurance, you are aware that all expenses that may happen because of your health problems will be you or your parents’ responsibility.

As an information, you can ask a help from International Office of POLINEMA to manage the health insurance.

**If yes**, please make sure that your health insurance is applicable in Indonesia.

Primary Insurance Company Name

Policy Number

Insurance Company Phone

**PART E: CERTIFICATION**

I certify that all responses made on this form are true, accurate and complete, and I will notify POLINEMA IO of any relevant changes that may occur prior to or during my study program. I have included in this form, advised the POLINEMA IO Staff of any special needs or assistance that I/the student may have relating to my/the student’s physical and mental health. I am aware that if I do not provide complete information, this may cause hardship and concern to others and may affect my/the student’s own welfare. I understand that if I do not provide complete information, POLINEMA IO may decide to send me/the student home from the study program at my/the student’s own expense.

I consent to the release of medical information to POLINEMA IO or POLINEMA agents so that they may provide me with needed assistance. I further agree that POLINEMA IO or POLINEMA agents may release information to other persons who may need this information to assist me/the student or to assist others in my study. I understand and agree that this form may be released to the POLINEMA IO staffs for such purposes.

I am aware that I am responsible for my/the student’s physical and mental health and will cover any medical expenses that may occur during my/the student’s study at POLINEMA.

*If my parents or guardians have not signed this form, I represent and certify that I am not a minor according to the laws of my country.*

Tick if this is the case 

Signature of Student:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Signature of Parent/Guardian

of student: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_