

*The present certificate is a compulsory document to be submitted during application to the International Coaching Course. The Hungarian University of Sports Science manages applicants' data based on the Privacy Statement for data management in connection with the university regulation in force.*

Full name of the applicant (as it appears on passport): \_\_\_\_\_

Date of birth: \_\_\_\_\_

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

<b>TYPE OF MEDICAL TEST OR VACCINATION</b>	<b>EXAMINATION / VACCINATION DATE</b>	<b>RESULT</b> (circle the relevant option)
<b>Tuberculosis (TB) screening</b> (chest X-ray within 3 months) or <b>Quantiferon test</b> Please attach the result (not the film) in English/Hungarian.		negative / positive
<b>SEROLOGICAL TESTS</b> (within 3 months, please attach results in English)		
<b>HIV</b>		negative / positive
<b>Hepatitis B</b> surface antigen (HBsAg)		negative / positive
<b>Hepatitis C antibody (anti-HCV/ HCV Ab)</b>		negative / positive
<b>VACCINATIONS</b> If available please attach Childhood Vaccination/Immunisation Records in English. If the patient is not vaccinated, please consider vaccination before arriving in Hungary.		
Has the patient been vaccinated against <b>diphtheria, tetanus and pertussis?</b> (dTap/Tdap booster should be given every 10 years)		Yes / No
Has the patient been vaccinated against <b>MMR (measles, mumps, rubella)?</b>		Yes / No
Has the patient been vaccinated against <b>poliomyelitis?</b>		Yes / No
Has the patient been vaccinated against <b>Coronavirus (COVID-19)?</b>		Yes / No
Has the patient been vaccinated against <b>Hepatitis B?</b>		Yes / No
Has the patient been vaccinated against <b>typhoid?</b> <i>Please note, that in case of patients from endemic countries if the patient had not been vaccinated against typhoid, vaccination is compulsory after entering Hungary, as part of the healthcare protocol*</i>		Yes / No

*\*to be filled out only in case of endemic countries*

**With my signature I hereby declare that the information provided in this form is correct.**

Date of issue: \_\_\_\_\_

signature and stamp of examining physician