Form No. SSD-7

RĪGA STRADIŅŠ UNIVERSITY

MEDICAL REPORT

We DO NOT accept medical reports issued by an involved party (family members and relatives). If your GP is also your relative, you must acquire the Medical Report from another doctor.

Patient's name:	*Surname, given name(s)*	Patient's date of birth:	*DD/MM/YYYY*

VISION TEST

Colour vision test is a mandatory requirement

Is the patient's vision impaired?	☐ Yes → *if 'Yes', please describe* ☐ No	
Colour vision/ Ishihara test result:	*Please state the results of the test/ examination findings here:*	

MEDICAL CONDITION/DISABILITY

Please describe any medication or treatment the patient has received during the past year, or is currently taking:

Please indicate if the patient has:

Specific learning difficulties (including Dyslexia/Dyspraxia)	☐ Yes ☐ No	
Physical/Mobility impairments and injuries (including wheelchair users)	☐ Yes ☐ No	
Mental health difficulties (e.g. nervous, emotional or mental abnormality)	☐ Yes ☐ No	
History of chronic diseases, long standing illnesses (e.g. epilepsy, asthma)	☐ Yes ☐ No	
Illnesses or contagious conditions	☐ Yes ☐ No	
Other disabilities, diseases, impairment, abnormalities	☐ Yes ☐ No	

VACCINATION INFORMATION (REQUIRED VACCINATIONS)

- ***The last vaccines/boosters must not be older than 10 years.***
- *Vaccination report may be submitted together with a photocopy of Vaccination Certificate.*
- *Should you currently have only 1 or 2 of the requested vaccines taken, please provide us with a indicative date when the next vaccine (2nd or 3rd accordingly) is planned to be taken.*

Vaccine	**Year of vaccination**			**Booster within the last 10 years**		
	1st	**2nd**	**3rd**			
TD-Tetanus/ Diphtheria				☐ Yes ☐ No	Date:	
Hepatitis B				☐ Yes ☐ No	Date:	

GENERAL CONCLUSIONS

In your expert opinion, is the patient's health condition suitable to commence studies in health sciences?

☐ Yes	☐ No

PERSONAL INFORMATION ABOUT THE PHYSICIAN

Name:		E-mail:	
Address:		Date of **patient's** examination:	
Signature and stamp:			