

## DECLARATION OF HEALTH

All information contained in this form is treated in a confidential manner.

Please complete the form in a legible way (in block letters). Thanks.

Name: \_\_\_\_\_ Surname \_\_\_\_\_

Birth date: \_\_\_\_\_

Address: \_\_\_\_\_

Postcode: \_\_\_\_\_ City: \_\_\_\_\_

A) Do you suffer from an allergy? Yes  No

If yes, specify which one and indicate the medical treatment prescribed:

\_\_\_\_\_

B) Do you follow a diet? Yes  No  If

yes, specify:

\_\_\_\_\_

C) Are you currently suffering from health problems or from consequences of an accident? Yes  No

If yes, specify:

\_\_\_\_\_

D) Are you on a medical treatment? Yes  No

If yes, specify:

\_\_\_\_\_

If yes, please, provide to the Service a medical certificate.

E) Are you on a psychological/psychiatric treatment? Yes  No

If yes, specify:

\_\_\_\_\_

If yes, please, provide to the Service a medical certificate.

F) Do you plan to undergo an operation or to be hospitalized? Yes  No

G) Do you suffer from alcoholism or other addictions (drugs, medicaments)? Yes  No

H) Do you smoke? Yes  No

I) Other health issues, if necessary:

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A false declaration stated at the points A) – H) can justify the Service to cancel of your enrolment to the program.

IN FAITH:

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

Signature: \_\_\_\_\_