

For applicants to the bachelor's degree programme in Classical Ballet.

Self-certification of Health Condition

The form Self-certification of Health Condition must be filled in and brought to the first day of auditions where it should be handed in to the jury. The form must NOT be uploaded to Søknavsweb as it may contain sensitive personal data.

The information will be handled confidentially and forms the basis for potential medical and physiotherapy assessment during and after the auditions.

Name:	Applicant number from Søknavsweb:
<input type="text"/>	<input type="text"/>

1	Over the past three years, have you	Yes	No
	a. suffered from conditions that have prevented you from training fully, lasting longer than one week?	<input type="checkbox"/>	<input type="checkbox"/>
	b. suffered from continuous pains/injuries lasting more than one month?	<input type="checkbox"/>	<input type="checkbox"/>
	c. consulted a physiotherapist/doctor or other forms of treatment due to the pains mentioned above? If yes, which measures have been put in place (such as alternative practice, training, treatment, operation or similar)?	<input type="checkbox"/>	<input type="checkbox"/>
2	Have you ever had a fracture? Where and when?	Yes <input type="checkbox"/>	No <input type="checkbox"/>
3	Have you ever had an operation in the muscle and/or the skeletal system? If yes, which types of operations and when?	Yes <input type="checkbox"/>	No <input type="checkbox"/>
4	Do you suffer from a chronic disease? If yes, which one(s)?	Yes <input type="checkbox"/>	No <input type="checkbox"/>
5	Do you suffer from asthma and/or allergies? If yes, how long have you been affected by this?	Yes <input type="checkbox"/>	No <input type="checkbox"/>
6	Do you or have you suffered from a heart or lung disease? If yes, which one(s) and when?	Yes <input type="checkbox"/>	No <input type="checkbox"/>
7	Do you suffer from issues related to stomach and/or intestine? If yes, which one(s) and when?	Yes <input type="checkbox"/>	No <input type="checkbox"/>
8	Do you have reduced vision and/or hearing? If yes, please describe to which degree.	Yes <input type="checkbox"/>	No <input type="checkbox"/>
9	Do you use medications regularly (not including contraception)? If yes, which one(s)?	Yes <input type="checkbox"/>	No <input type="checkbox"/>

I hereby confirm that the information given regarding my health is true:

Place/date: _____ Signature: _____