

DOCTORS CERTIFICATE

with enrollment to the 3-Month Course in yoga and meditation at
 SCANDINAVIAN YOGA AND MEDITATION SCHOOL
 Håå Course Centre, S-340 13 Hamneda, Sweden. Tel. 0046 372 55063

The examined:

Identity number:..... Occupation:

Name:

Address:

Telephone (day/evening):

Identification verified by: personal acquaintance passport other means of identification

Completed by the doctor according to the information received from the examined:

<i>The examined has or has had:</i>	<i>Yes No</i>		<i>Yes No</i>	<i>If yes, give further information</i>
Skin disease	<input type="checkbox"/> <input type="checkbox"/>	Kidney disease	<input type="checkbox"/> <input type="checkbox"/>	
Eye-/ear complaints	<input type="checkbox"/> <input type="checkbox"/>	Diabetes	<input type="checkbox"/> <input type="checkbox"/>	
Acute rheumatic fever	<input type="checkbox"/> <input type="checkbox"/>	Goitre or other		
Chronic joint-disease	<input type="checkbox"/> <input type="checkbox"/>	endocrinal sickness	<input type="checkbox"/> <input type="checkbox"/>	
Sciatica/ back problems	<input type="checkbox"/> <input type="checkbox"/>	Tuberculoses	<input type="checkbox"/> <input type="checkbox"/>	
Allergy	<input type="checkbox"/> <input type="checkbox"/>	Mental or nervous		
Heart-/vascular disorders	<input type="checkbox"/> <input type="checkbox"/>	ailments	<input type="checkbox"/> <input type="checkbox"/>	
Lung diseases	<input type="checkbox"/> <input type="checkbox"/>	Organic nervous disorders	<input type="checkbox"/> <input type="checkbox"/>	
Disorders of inner organs	<input type="checkbox"/> <input type="checkbox"/>	Other prolonged or		
Serious phys. handicaps	<input type="checkbox"/> <input type="checkbox"/>	serious illnesses	<input type="checkbox"/> <input type="checkbox"/>	
Does the examined take medicine?		If yes, what kind and since when?		
<input type="checkbox"/> Yes <input type="checkbox"/> No				
Will the examined use medicine during the course?		If yes, what kind and for how long?		
<input type="checkbox"/> Yes <input type="checkbox"/> No				
Does he/she consider him/herself to be in good health?		If no, for what reason:		
<input type="checkbox"/> Yes <input type="checkbox"/> No				

I hereby assure that all the particulars above are correct. I am aware that deliberately falsifying information can influence the conditions for my participation on the course.

.....
Place and date

.....
Signature of the examined

State of health at time of examination:

Body's constitution, general health, skin Mouth, nose, throat, voice, speech, teath Thyroid gland Circulatory organs, varicose veins Respiratory organs Inner organs, hernia Posture- and locomative organs	No comment	Comment	
Blood pressure	Urine: albumin.	Sugar	Sediment

Indication of organic nervous disorder, mental or nervous ailment or peculiarity, eye or ear ailment as well as other illnesses or points worth mentioning:

Declaration

- No other comments on the condition of the examined.
 The following comments on the condition of the examined:

.....
Place and date

.....
The Doctor's signature

Doctor's address and telephone (stamp):