

HEALTH QUESTIONNAIRE

Please complete **ALL** sections of the questionnaire (except where these are indicated as applicable only for entry to certain professions). You should refer to the 'Guidance Notes' to assist you in doing this. **If you require this questionnaire in an alternative format, please address your enquiry to the University's Student Health Service, via a call to the Information HelpDesk on 01227 782222 or i-zone@canterbury.ac.uk.**

Please complete in **BLOCK CAPITALS** and use **BLACK BALL-POINT PEN ONLY**.

Once completed, you should photocopy this form for your own record, prior to returning it.

DO NOT RETURN IT UNTIL ALL RELEVANT SECTIONS OF THE FORM HAVE BEEN FULLY COMPLETED AND YOUR GP HAS COMPLETED SECTION B, OTHERWISE IT WILL BE RETURNED TO YOU AND YOU WILL NOT BE ABLE TO TAKE UP YOUR PLACE AT THE UNIVERSITY UNTIL ANY OUTSTANDING MATTERS ARE ADDRESSED.

NOTE 1	Surname		Dr Mr Mrs Miss Ms
	First Names		
	Previous Name(s) (if any)		
	Address (inc post code)		
NOTE 2	email		
	Telephone Nos	(Home)	(Mobile)
NOTE 3	Date of Birth (dd/mm/yy)		Age (years)
NOTE 4	Nationality and place of birth		
NOTE 5	University Programme		
	Start Date (Month/Year)		

For Office Use Only	Date		Signed
Cleared	Yes	No	
	GP	sent	
		recd	
	Spec	sent	
		recd	
Final Clearance	Yes	No	

SECTION A - Self Declaration

Please answer **every** question, giving all details, treatments and dates. Please note that answering 'yes' to any of these questions will not automatically exclude you from entry to any particular programme. Giving full and comprehensive information about your health status will help to speed up the assessment process.

1. FITNESS FOR PURPOSE

I believe that I am fully able to meet the specific demands that are likely to be placed on me whilst training for my chosen profession on this programme. YES NO

If NO, please explain your answer. Give details of any medical or other conditions, and include details of any treatments given.

NOTE 6

DO YOU CURRENTLY HAVE OR
HAVE YOU EVER HAD:

IF 'YES', PLEASE GIVE DETAILS OF
TREATMENTS & DATES BELOW

ALL STUDENTS

PLEASE ✓

Fits, faints, convulsions, epilepsy or other
neurological problems

YES NO

Depression, emotional or nervous troubles, psychiatric,
psychological or mental health problems

YES NO

Alcohol or drug-related problems

YES NO

An attempted suicide, intentional self-harm or
an eating disorder of any kind

YES NO

ME or Post-viral Fatigue Syndrome

YES NO

Any long-term medical condition, such as heart disease,
diabetes, neurological disease or other chronic condition

YES NO

ALL STUDENTS EXCEPT EDUCATION AND SOCIAL WORK

A rash or skin problems including eczema and dermatitis

YES NO

Any condition (such as arthritis, painful joints or
muscles, back/neck pain or injury or spinal deformity)
which may affect movement or manual handling etc.

YES NO

An allergy to medicines, chemicals or other
substances (such as latex)

YES NO

Chickenpox

YES NO

Have you or anyone in your close family (eg parents,
siblings), ever had TB

YES NO

2. GENERAL HEALTH AND LIFESTYLE

I believe that my general health and lifestyle are compatible with the pursuit of my chosen profession. YES NO

If 'NO' please explain:

NOTE 7

My height is: _____

My weight is _____

NOTE 8

I drink _____ units of alcohol per week on average.

I smoke _____ cigarettes (or equivalent
in tobacco) per week on average

I have had _____ days absent from school/work in the last two years due to illness. Please give reasons.

I have had to leave employment/college/university on the grounds of ill-health or for unsatisfactory attendance.

YES NO

If 'YES' please give details

I have used the following recreational drugs in the past 5 years. Please give substance(s), frequency of use, and date of last use.

If none, please state 'none'

I am currently taking the following medication (ie injections, tablets, medicines). Please give name or description of medication and dosage. (If none, please state 'none')

3. ADDITIONAL SUPPORT

I believe that I am able to complete this programme without any special support arrangements or adjustments made.

YES NO

If 'NO' please explain your answer in the box below. Give details of any medical condition or disability or learning difficulty, and give details of any treatment given or support arrangements required, so that the University's Disability Adviser can discuss this with you, in due course.

NOTE 6

DO YOU CURRENTLY HAVE OR
HAVE YOU EVER HAD:

PLEASE ✓

IF 'YES', PLEASE GIVE DETAILS OF
TREATMENTS AND DATES BELOW

Any disability for which you will require support in order to undertake your chosen programme of study (including placements) YES NO

Any chronic illness which will impact upon your ability to undertake your programme of study (including placements) YES NO

Any learning difficulty (eg dyslexia) for which you will require support in order to undertake your chosen Programme of study. YES NO

Please give further detail on a separate sheet if necessary

Surname	First Name (s)	Date of Birth

SECTION B - Health Declaration by Family Doctor or Practice Nurse

NOTE 9

Please ask your GP or GP Practice or Practice Nurse to complete this section.

If the answer to the question below is 'YES' the University Occupational Health Doctors will request further information before a decision on acceptance can be made. Any information supplied will be in strict confidence to the University's Student Health Service and OH Service, and will only be discussed with other essential staff at the University with your express permission.

NOTE 10

Some GPs make a charge for the completion of this section. The University will reimburse up to £10 (Health and Social Care students ONLY, with the exception of Social Work), on production of a receipt – please email studentfinancialsupport@canterbury.ac.uk for further information.

Does the person named above have any history of any of the following:

Bulimia, anorexia, eating disorder or self-harm; depression or anxiety states; obsessive compulsive disorder; any psychotic illness; any other psychiatric illness; drugs or solvent misuse; alcohol-related illness; behavioural problems; any significant physical or medical condition such as back problems, arthritis, skin conditions, cardio-vascular or respiratory conditions? YES NO

If 'YES' please give details and approximate dates:

Signed: GP
 Practice Nurse

Date:

Practice Stamp:

SECTION C – Immunisations etc

NOTE 11

Health and Social Care students ONLY (with the exception of Social Work), and NOT Education students. Please read Section C of the Guidance Notes carefully before completing this section. Only if you have had any of the vaccinations or tests below, please ask your GP or Practice Nurse to provide details, otherwise you will need to have these done when you start at university in order to be fully registered and commence any placements.

Vaccine / Test	Date Done	Signature of GP/ Practice Nurse
Hepatitis B 1 st		
Hepatitis B 2 nd		
Hepatitis B 3 rd		
Hepatitis B blood test / status		
MMR (first)		
MMR (second)		
Rubella		
Rubella blood test		
BCG - scar or other evidence of vaccination or immunity		

Surname	First Name (s)	Date of Birth

SECTION D - Declaration by Candidate

NOTE 12

I declare that to the best of my knowledge information given in this questionnaire is true and complete.

I understand that failure to disclose information or giving false information may result in withdrawal of the offer of a place at the University or in termination of my place on a programme.

SIGNED: _____ DATE: _____

NOTE : If you have answered 'YES' to any of the statements in Section A it is likely that the Occupational Health Doctor will require a report from your GP or Consultant. Therefore, would you please complete the consent form in section E. You have a right to see any report before it is sent to us, and we will let you know in writing if we have written to your doctor.

SECTION E - Consent to Obtain Medical Report

NOTE 13

In order to assess your fitness to undertake your programme, it may be necessary to obtain additional information about your health.

Before you sign below you should be aware that you have certain rights under the Access to Medical Reports Act 1988. In summary these rights are:

1. To withhold your consent for an application to be made to your doctor.
2. You may request to see a report before it is sent to us. You must arrange this with your doctor to see it within 21 days. You may ask to see a copy of the report for up to 6 months after it is requested.
3. You may ask the doctor to amend any part of the report that you feel is misleading or inaccurate.
4. If the doctor declines to amend any part of it, you may attach a written statement giving your views on its content, or
5. You may withdraw your consent to the report being sent to the Occupational Health Department.
6. The doctor may withhold from you any section of the report if (s)he thinks you would be harmed by seeing it.

NOTE 14

I *agree / do not agree to a medical report on my health being requested

I *do / do not wish to see this report before it is provided

I understand that a copy of this consent form will be sent to my doctor and that this copy shall have the validity of the original.

Signed: _____ Date: _____

NOTE 15

Name and address of General Practitioner	Name and address of specialist(s)

NOTE 16

THIS QUESTIONNAIRE IS CONFIDENTIAL TO THE UNIVERSITY OCCUPATIONAL HEALTH SERVICES. ONCE FULLY COMPLETED, PLEASE RETURN IT IMMEDIATELY TO THE UNIVERSITY'S CANTERBURY ADDRESS IN A SEALED ENVELOPE MARKED 'STUDENT HEALTH SERVICE (STUDENT SUPPORT AND GUIDANCE)' AND WRITE YOUR NAME AND PROGRAMME DETAILS ON THE BACK OF THE ENVELOPE. IF YOU ARE HAND-DELIVERING THIS, THE ENVELOPE SHOULD GO TO 'RECEPTION' IN AUGUSTINE HOUSE, CANTERBURY. PLEASE SEND SEPARATELY AND DO NOT INCLUDE WITH OTHER ITEMS TO BE RETURNED TO THE UNIVERSITY. IF WE HAVE TO RETURN THE QUESTIONNAIRE TO YOU BECAUSE IT IS NOT FULLY COMPLETED THIS WILL PREVENT YOU FROM TAKING UP YOUR PLACE AT THE UNIVERSITY.

***delete as necessary**