Occupational Health Service
The University of Manchester

CONFIDENTIAL

PRE-ACCEPTANCE HEALTH SCREENING QUESTIONNAIRE

For Prospective Students (Undergraduates and Postgraduates) Applying for Health Care/ Teaching Courses (subject to the relevant Regulatory Body).

Now that you have been made a conditional / unconditional offer of a place to study at The University of Manchester we need to be aware of any disabilities or health conditions which could be relevant to your proposed course of training and future employment. Where considered appropriate we can then advise your chosen School of the need to consider any reasonable adjustments or additional support needs both in your own and future patients/pupils interests.

The University of Manchester is committed to providing equality of opportunity for disabled students and where possible all reasonable support will be provided to enable them to complete the course. However, for those undertaking Healthcare Studies/PGCE, we need to ensure that they will be able to fulfil the requirements of the relevant regulatory body (e.g. GMC/ GDC/ NMC etc) and following graduation be medically suitable to work within their chosen field.

In the rare case that it is decided that you are medically unsuitable for the course The University will provide you with advice and will make every endeavour to offer you a place on an alternative course.

You have a duty to provide all relevant, truthful and accurate information to The University's Occupational Health Service and no information should be withheld. Any failure to do so may result in the offer of a place being withdrawn or reconsideration of your fitness to continue with the course.

You can be assured that the information will remain confidential to the staff of the Occupational Health Service. The School will only be informed of the functional effects of any health problems/ disability if this is relevant to your educational needs or pupil/ patient safety and of the need to consider reasonable adjustments and/ or additional support.

Please start by completing **Section 1** and go on to each of the following questions in **Section 2** and in the case of positive answers provide additional information in the space provided (or attach details if space is insufficient). Following this, complete the declaration and arrange for your GP to complete **Section 3** including the vaccination history. You are strongly advised to complete your vaccination history sheet fully. Any omission of full details could delay your screening process. The completed document should then be sent to The University's Occupational Health Service.

Please note that a number of other universities have agreed to accept The University of Manchester's health screening questionnaire and you are therefore advised to keep a photocopy.

Having considered your completed form the Occupational Health Service may consider it appropriate to contact you for further information.

SECTION 1

Personal Details:

University User ID							
Family Name:				Forename:			
Title:				Date of Birth:			
Nationality:				Sex: M / F			

University Term Time Address (if known)		Vacation / Home Address
(1)	(2)	
Postcode:	Postcode:	Postcode:
Tel No:	Tel No:	Tel No:
Mobile:	Mobile:	Mobile:
Email:	Email:	Email:

GP's Name and Address	Term Time	Vacation (if relevant)
Tel No:	Tel No:	Tel No:

Course Details:

What is your proposed course	
Date of proposed entry	
Length of course	

Work / Employment History: (if applicable)

Nature of Work	Employer	Start Date	Finish Date

Have you ever had to finish or leave work on health grounds? (Please ✓ as applicable)	Yes	No

If **yes**, please supply details.

Have you ever previously registered at a higher education college/ University for a course of study? (Please ✓ as applicable)	Yes	No

If **yes**, please supply details.

Name of College / University	Start Date	Leaving Date

If you failed to complete the course, please provide details:

SECTION 2

Your Health and Functional Capabilities:

			Yes	No
1	**Do you have problems with any of the following:-**			
	a.	**Mobility?** e.g., walking, using stairs, balance:		
	b.	**Agility?** e.g., bending, reaching up, kneeling down:		
	c.	**Dexterity?** e.g., getting dressed, writing, using tools:		
	d.	**Physical Exertion?** e.g., lifting, carrying, running:		
	e.	**Communication?** e.g., speech, hearing:		
	f.	**Vision?** e.g., visual impairment, colour blindness, tunnel vision:		
If **YES** to any of the above, please give details (e.g., extent of impairment, how you manage, support needs):				

2.	**Have you ever required special arrangements at school or work to accommodate a disability or health problem? (e.g. special equipment, extra time in exams, part-time working)?**	Yes	No
If YES please give details:			

3	**Do you have, or have you had, any of the following?**		Yes	No
	a.	**Chronic Skin Condition?** e.g., eczema, psoriasis.		
	b.	**Neurological Disorder?** e.g., epilepsy, multiple sclerosis.		
	c.	**Allergies?** e.g., latex, medicines, foods.		
	d.	**Endocrine Disease?** e.g., diabetes.		
	e	**Hep B/ Hep C/ HIV?**		
If **YES** to any of the above please give details (e.g. when condition developed, severity, effects and treatment):				

4	**Have you ever been affected by:**		Yes	No
	a.	**Sudden Loss of Consciousness?** e.g., fit or seizure:		
	b.	**Chronic Fatigue Syndrome?**(or similar condition):		
	c.	**Mental Health Issues?** e.g., anxiety, depression, phobias, OCD, nervous breakdown, personality disorder, over-dose or self-harm, drug or alcohol dependency:		
	d.	**An Eating Disorder?** e.g., bulimia, anorexia nervosa, compulsive eating:		
	e.	**An illness requiring more than two weeks' absence from school or work?**		
If **YES** to any of the above please give details:				

5	**Have you ever received treatment from a psychiatrist, psychotherapist or counsellor?**	**Yes**	**No**
If **YES** to any of the above please give details:			

		Yes	**No**
6	**Are you currently taking any medication or treatment?**		
If **YES** to any of the above please give details:			

		Yes	**No**
7	**Do you have any disability or health condition not already mentioned for which you think you may require support during your employment/ education or training?**		
If **YES** to any of the above please give details:			

8	**What is your height?**		**What is your weight?**	

If you would like any further advice on your health in relation to your course, please contact the Occupational Health Service, Waterloo Place, Oxford Road - Tel: 0161 275 2858.

In the case of prospective Nursing and Social Work Students please contact the Occupational Health Services, The Mill, Sackville Street, Manchester M13 9PL - Tel: 0161 306 5806

Note: Ensure you have answered ALL questions.
Your assessment cannot be completed until you do.

Declaration:

I certify that my answers to the questions are complete, accurate and no information has been withheld. I understand that if this is later shown not to be the case it may result in the offer of a place being withdrawn or reconsideration of my suitability to continue with my course.

The information supplied by you on this questionnaire will be used to produce a certificate. This will be forwarded to your School as evidence of your fitness to study.

I give my consent for my General Practitioner/Doctor to provide the medical staff at the University Occupational Health Service with any medical information relevant to my application.

Name:	Signature:	Date:

Please take completed and signed form together with your vaccination record to your General Practitioner/Doctor and request that he / she completes the enclosed form.

You will be responsible for any fee if this is required by your General Practitioner/Doctor.

Data Protection Information

If you join the University this questionnaire will form the basis of your Occupational Health record. If you do not join, your questionnaire will be destroyed.

- Records are held in confidence by The University's Occupational Health Service.
- No identifiable medical or other information you provide in confidence and contained in your Occupational Health record will be released by the Occupational Health Service to anyone else without your consent being obtained.
- You may obtain access to your Occupational Health record by contacting the Occupational Health Service.
- The University of Manchester will not share your information with any third party. For further information of your rights to access data which we hold about you please contact the Records Management Office Tel: 0161 275 8111 and e mail dataprotection@manchester.ac.uk

- **Please return your completed Pre – Acceptance Health Screening Questionnaire to:**

  Occupational Health Services, Waterloo Place, 182-184 Oxford Road, Manchester M13 9GP
  Tel: 0161 275 2858 Fax: 0161 275 3137

  OR

  Occupational Health Services, B22 The Mill, Sackville Street, Manchester M13 9PL
  Tel: 0161 306 5806 Fax: 0161 306 3245 **(Applicable to Nursing and Social Work Students only)**

  OR

  Alternatively as advised by your school.

VACCINATIONS & DISEASES

Please give details of your vaccinations or known illness against the following diseases. These details may be available from your general practitioner's/Doctor's medical records. If your General practitioner/Doctor is not in full possession of your vaccination history please contact your local Child Health Records Department, which is based at your local Health Authority. Any further screening / vaccination procedures will be undertaken by Occupational Health, early into your course.

BCG (Tuberculosis):		
	Yes	**No**
Have you had Tuberculosis:		
Is there a family history of Tuberculosis?		
Have you lived or worked abroad for a period greater than 3 months?		
If **YES** please give details of: Date:		
Country:		
	Yes	**No**
Have you been vaccinated against Tuberculosis?		
If **YES** please give details of:		
Date of Tuberculosis vaccination (BCG):		
	Yes	**No**
Do you have a visible scar (usually located on the upper arm)?		
Have you had a recent chest x-ray?		
If **YES** please supply details of dates and location:		

MMR (Measles, Mumps and Rubella) / Varicella (Chicken Pox) Please specify:							
I have had the following disease(s):	**Yes**	**No**	**Don't Know**	**I have received the following vaccinations:**	**Yes**	**No**	**Date Received:**
Measles:				Measles:			
Mumps:				Mumps:			
Rubella:				Rubella:			
				MMR:			
Chicken Pox:				Varicella:			

Hepatitis B:		
	Yes	**No**
Have you previously worked with human tissue, blood or bodily fluids?		
Have you ever been offered Hepatitis B vaccinations?		
If **YES** please provide the following dates and details:		

Date of 1st Dose	**Date of 2nd Dose**	**Date of 3rd Dose**	**Date of blood test**	**Result of blood test Iμ/l**	**Date of Booster**

Other:					
Vaccinations:	**Dates Of Vaccinations:**				
Pertussis (Whooping Cough)	1st	2nd	3rd		
Polio	1st	2nd	3rd	4th	Booster
Tetanus	1st	2nd	3rd	4th	Booster
Diphtheria	1st	2nd	3rd	4th	Booster
Meningitis C					
Other (specify)					

Please ensure that you have answered ALL of the questions. Your assessment cannot be completed until you do.

SECTION 3

General Practitioner's/Doctor's Certificate

Your patient has been offered a place to study at The University of Manchester. All prospective students undertaking a course subject to the requirements of a regulatory body e.g. GMC/ GDC/ NMC etc., are required to complete a health questionnaire to enable the University to assess their medical fitness and where appropriate consider any reasonable adjustments or additional support needs.

We would ask for your co-operation in verifying the health information provided by the prospective student:

	Please ✓ the appropriate answer	YES	NO
1.	Are you the applicant's usual General Practitioner/Doctor?		
2.	Are you the relative of the applicant?		
3.	Do you hold the applicant's medical record?		
4.	According to your records and knowledge of the applicant, do the answers to questions in Section 2 appear correct/ full/ accurate? (please add any comments below, if appropriate)		
	Comments:		
5.	Are you aware of any additional medical information which may be relevant to this application? (if **yes** please provide details)		
	Details:		

General Practitioner's/ Doctor's Signature:

_____

Date: _____

Practice Stamp

PLEASE NOTE: A medical examination is not required.

Any fee required for completion of the form is the responsibility of the patient

Thank you for your co-operation in completing this form

Following discussions with the British Medical Association and others it has been agreed that this medical assessment form will also be accepted by the following Universities:

Peninsula Medical School

Queen's University Belfast

University of Glasgow

University of Oxford

The University of Manchester

The University of Sheffield