ST GEORGE'S HEALTHCARE NHS TRUST
STAFF/STUDENT OCCUPATIONAL HEALTH DEPARTMENT
St. George's Hospital, Blackshaw Road, Tooting, SW17 0QT
in association with
KINGSTON UNIVERSITY AND ST. GEORGE'S, UNIVERSITY OF LONDON
FACULTY OF HEALTH AND SOCIAL CARE SCIENCES

CONFIDENTIAL HEALTH QUESTIONNAIRE

Complete after you have received an offer of a place in the course. The contents of this form are held in strict confidence by the Occupational Health Department.

INSTRUCTIONS:

- Please complete the Health Questionnaire **fully** and in BLACK INK. Leaving questions unanswered will delay the health clearance and your start date for the course.
- You are **required to take the additional questionnaire (Report from General Practitioner) with signed consent form to your general practitioner** for completion. You will have to meet any charges levied by the General Practitioner.
- You should return your questionnaire, **together** with the General Practitioner Questionnaire, in the envelope provided **as soon as possible to ensure that you are health cleared by the start date.**

Course Title:	

Title (delete):	Dr/Mr/Mrs/Miss/Ms/other	**First Name:**	
Surname:		**Maiden Name (if applicable):**	
Date of Birth:		**Gender (delete):**	Male/Female
Home address:		**Home Telephone:** **Mobile Telephone:** **Email address:**	

General Practitioner's details below:			
Name:		**Telephone No:**	
Address:			

The University is fully committed to supporting students with disabilities. A careful assessment will be carried out to identify the areas in the course where a health condition may impact your studies and support will be arranged. If your health will impact on achieving the competencies required for the course, we will look at reasonable adjustment with the involvement of senior teaching staff. You will only be rejected on medical grounds if it is shown that you will not meet the core competencies of the course despite the adjustments and the decision will be made after consulting senior staff of the University.

YOU ARE REMINDED THAT IF YOU KNOWINGLY MAKE A FALSE STATEMENT OR CONCEAL ANY INFORMATION REGARDING YOUR MEDICAL HISTORY, YOU WILL BE LIABLE TO HAVE YOUR TRAINING TERMINATED.

PLEASE ANSWER THE FOLLOWING QUESTIONS BY TICKING THE APPROPRIATE YES/NO BOX. IF THE ANSWER IS <u>YES</u> PLEASE GIVE DETAILS IN THE SPACE PROVIDED. YOU SHOULD CONTINUE ON THE NEXT PAGE IF NECESSARY.

All questions MUST be answered				
	Health Question	**Yes**	**No**	**If Yes:** • give details in the box in this column and the box next page • Enclose any hospital reports that outline the problems you have declared
1	Are you at present, receiving any treatment or regular medication supervised by your doctor? If yes, give details:			
2	Have you lost time from Work/School due to illness in the last 2 years?			*Please state how many days or weeks and on how many occasions and the reasons.*
3	Have you ever received medication, seen a doctor, a therapist, counsellor or admitted or treated for the following:			
	a) Mental Health problems *(including anxiety, phobias, depression, bi-polar disorders, psychosis, schizophrenia, eating disorders, obsessive compulsive disorder, autism or related disorders or personality disorder?*			
	b) Use or have you used illegal / recreational drugs or do you have or have you had any alcohol/substance misuse problems? What is your weekly alcohol consumption?			
	c) Musculoskeletal problems (such as arthritis, pains in arms or legs, neck or back pain)?			
	d) Epilepsy or recurrent faints?			
	e) A neurological condition or injury that affected your memory or concentration?			
	f) Diabetes?			
	g) Chronic fatigue			
	h) Cough which lasted for more than 3 weeks, weight loss or have been investigated for Tuberculosis?			
	i) positive to or carrier of Hepatitis B, C, HIV or have a infectious disease such as typhoid			
	j) Did you have cancer or Immuno-suppression due to an illness or taken high dose steroid or chemotherapy within the past one year?			
	k) Allergies including sensitivity to medicines, vaccines, detergents, Latex or other gloves			
4	Have you had or anticipate difficulty doing overnight or 12 hours shifts?			
5	Hearing impairment for which you attended a hospital clinic for assessment or wear a hearing aid?			
6	Visual impairment (including colour vision) that could not be corrected by wearing spectacles?			
7	Do you have dyslexia or dyspraxia? If so, please enclose relevant reports.			
8	Any **other health conditions** not declared above requiring hospital treatment, investigation or may impact on your studies? If yes please give details			
9	Did you receive any support such as extra time, equipment and special adjustments at school/ university/work with learning, examinations, assessments and work place attachments? Please give details			
10	**Weight (kg)**		**Height (meters)**	

Please give much detail as possible to the questions you have responded yes in the previous page. This will minimize delay in processing your health clearance. Give details of the main symptoms, diagnosis, details of the investigations, treatment, current symptoms and treatment.

Attach relevant medical and assessment reports.

YOU MAY BE REQUIRED TO UNDERGO A HEALTH EXAMINATION/ OCCUPATIONAL MEDICAL EXAMINATION BEFORE BEING FINALLY HEALTH CLEARED.

IMMUNISATION RECORD

There are strict immunity screening and vaccination requirements marked by * for entry to healthcare science courses. You must give information and attach copy of reports and vaccine records. **You will not be health cleared without the essential immunity information.**

Read the document **'Important immunity and vaccination requirements before starting your course'**

IMMUNISATION / TEST **N.B. State if you have had the disease**	**DATE/YEAR OF IMMUNISATION/ TEST OR DISEASE**	**WHERE PERFORMED e.g. GP/Occ.Health**	**RESULT (if applicable)**
TRIPLE VACCINATION (Diphtheria, Whooping Cough, Tetanus combined - usually in infancy)			
TUBERCULOSIS SKIN TEST Method if known (eg. HEAF,TINE,MANTOUX)			Result indicated immunity: **YES / NO / NOT KNOWN**
***B.C.G.**			Scar present: - **YES / NO** Scar larger than 4mm diameter: **YES / NO**
WHOOPING COUGH			
TETANUS			
POLIO			
DIPHTHERIA			Schick Test: - **YES / NO**
***MEASLES**			
***MUMPS**			
***RUBELLA** **(German Measles)**			Antibody Test: - **YES / NO** Immune: - **YES / NO / NOT KNOWN**
***M.M.R.** (Measles, Mumps, Rubella)			
***CHICKEN POX** STATE THAT YOU HAVE HAD THE DISEASE ONLY IF CERTAIN			Antibody Test: **- YES / NO** Immune: - **YES / NO / NOT KNOWN**
HEPATITIS A			Antibody Test: - **YES / NO** Immune: - **YES / NO / NOT KNOWN**
***HEPATITIS B**			Antibody Test: - **YES / NO** Date of Last Test: Immune: - **YES / NO / NOT KNOWN** Carrier State Positive : **YES / NO / NOT KNOWN**
TYPHOID			
CHEST X-RAY if you had one			

There are **mandatory requirements for immunity screening and vaccination**. Places are offered on the understanding that the applicant will comply with local requirements regarding IMMUNISATIONS. Please state whether you agree to this: **YES /NO (delete)**

DECLARATION:

The answers in this questionnaire are true and complete to the best of my knowledge.

Signed: ..... Date: .....

Print Name: .....