

A declaration of an applicant's past and present health status is a requirement for entry into this programme. While health problems are not a barrier to entering a programme, it is important that the Programme Leader is aware of them and can discuss them fully with you. Please answer all questions in this section, then make an appointment with your Doctor who should complete the medical report section.

THE INFORMATION GIVEN WILL BE HELD IN THE STRICTEST CONFIDENCE.

SECTION A - to be completed by applicant

Family Name

First Name(s)

Address

Telephone Number

May we approach your Doctor if necessary to do so?

No Yes

If Yes, please give your Doctor's name and address

Programme applied for

Have you ever suffered from any of the following?

No	Yes	
<input type="checkbox"/>	<input type="checkbox"/>	1 Back problems
<input type="checkbox"/>	<input type="checkbox"/>	2 Joint problems
<input type="checkbox"/>	<input type="checkbox"/>	3 Foot or leg problems
<input type="checkbox"/>	<input type="checkbox"/>	4 High blood pressure
<input type="checkbox"/>	<input type="checkbox"/>	5 Rheumatic Fever
<input type="checkbox"/>	<input type="checkbox"/>	6 Heart complaint
<input type="checkbox"/>	<input type="checkbox"/>	7 Allergies of any kind
<input type="checkbox"/>	<input type="checkbox"/>	8 Varicose veins
<input type="checkbox"/>	<input type="checkbox"/>	9 Sight defects
<input type="checkbox"/>	<input type="checkbox"/>	10 Head injury
<input type="checkbox"/>	<input type="checkbox"/>	11 Severe or recurrent headaches
<input type="checkbox"/>	<input type="checkbox"/>	12 Epilepsy, fainting attacks, fits or blackouts
<input type="checkbox"/>	<input type="checkbox"/>	13 Diabetes or kidney complaints
<input type="checkbox"/>	<input type="checkbox"/>	14 Asthma, bronchitis, pleurisy or lung disease
<input type="checkbox"/>	<input type="checkbox"/>	15 A substance related disorder, dependence or abuse
<input type="checkbox"/>	<input type="checkbox"/>	16 Mental illness requiring psychiatric care
<input type="checkbox"/>	<input type="checkbox"/>	17 Are you on medication?
<input type="checkbox"/>	<input type="checkbox"/>	18 Other, please specify _____

Signature of applicant

Date

Day	Month	Year
-----	-------	------

SECTION B - to be completed by Doctor

Name of applicant

Are you this person's regular Doctor?

No Yes

Please list any current or chronic condition(s) which require(s) regular or periodical medical attention and describe any condition/ disability of any nature which may affect successful completion of the programme. (Any previous problems which may recur should also be noted here.)

Please state medications of any kind which the applicant is currently taking or has taken in the previous three months (excluding oral contraceptive.)

Name

Address

Signature

Date

Day	Month	Year
-----	-------	------

Please complete next (attached) page regarding applicant's immune status.

SECTION C - to be completed by Doctor

Name of applicant

What is the applicant's immune status? (If unsure, serology must be checked.)

Vaccination / Immunisation	Yes (please tick)	If yes, please advise date	No (please tick)	If no, please advise date of serology results	Result of serology Immune / not immune
Tuberculosis (TB) (BCG)				N/A	N/A
Hepatitis A					
Hepatitis B					
Hepatitis C (Not applicable for nursing students)					
Measles					
Mumps					
Rubella					
Chicken Pox					
Tetanus				N/A	N/A

This completed Health Declaration **MUST** be returned by the doctor to:

Student Registry
 UCOL
 Private Bag 11022
 Palmerston North