UCOL
Te Pae Mātauranga ki te Ao
Universal College of Learning

General Health Declaration Form

A declaration of an applicant's past and present health status is a requirement for entry into your programme of study. While health problems are not a barrier to entering a programme, it is important that the Academic Portfolio Manager is aware of them and can discuss them fully with you.

The information given will be held in the strictest confidence.

Section A - to be completed by applicant

Personal Details

Legal First Name(s):

Legal Surname:

Date of Birth: DAY MONTH YEAR

Student ID (if known):

Current Address:

STREET ADDRESS

SUBURB TOWN OR CITY POSTCODE

Phone Number:

May we approach your Doctor if necessary to do so? ☐ Yes ☐ No

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

Programme applied for:

Have you ever suffered from any of the following?

Yes	No		Yes	No	
☐	☐	Back problems	☐	☐	Severe or recurrent headaches
☐	☐	Joint problems	☐	☐	Epilepsy, fainting attacks, fits or blackouts
☐	☐	Foot or leg problems	☐	☐	Diabetes or kidney complaints
☐	☐	High blood pressure	☐	☐	Asthma, bronchitis, pleurisy or lung disease
☐	☐	Rheumatic Fever	☐	☐	A substance related disorder, dependence or abuse
☐	☐	Heart complaint	☐	☐	Mental illness requiring psychiatric care
☐	☐	Allergies of any kind	☐	☐	Are you on medication?
☐	☐	Varicose veins	☐	☐	Other, please specify
☐	☐	Sight defects			
☐	☐	Head injury			

Signature:

Date: DAY MONTH YEAR

Section B - to be completed by Doctor

Medical Information

Full name of applicant:

Are you this person's regular Doctor? ☐ Yes ☐ No

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.)

Doctor Name:

Address:

STREET ADDRESS

SUBURB | TOWN OR CITY | POSTCODE

Doctor Signature:

Date: DAY | MONTH | YEAR

Doctor/Practice Stamp: