

Welcome to UCOL

A declaration of an applicant's past and present health status is a requirement of entry into your programme. 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. Please answer all questions in Section A, then make an appointment with your doctor who should complete the medical report sections.

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

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 the next page regarding the 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 B					
Measles					
Mumps					
Chicken pox / Varicella					
Pertussis					
Covid-19				N/A	N/A

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

UCOL
Palmerston North
New Zealand

Email: internationalstudent@ucol.ac.nz

Doctor signature

Date

DAY	MONTH	YEAR
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Doctor / Practice stamp