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**Occupational Health Service**

**The University of Manchester**

**CONFIDENTIAL**

**PRE-ACCEPTANCE MEDICAL FITNESS ASSESSMENT**

*To be used by offer holders for undergraduate and postgraduate courses in the following areas:-*

***Medicine, Nursing, Midwifery, Social Work, Audiology, Speech & Language Therapy, Dentistry, Oral Health Sciences, Optometry, Pharmacy, Clinical Psychology, Physician Associate, PGCE, School Direct & Teach First.***

***Medical fitness assessment may also be required where programmes have a significant clinical component. A full list of courses requiring medical fitness assessment can be found in the Procedure for admitting applicants to courses that require a medical fitness assessment at :-***

[***http://www.manchester.ac.uk/study/undergraduate/applications/after-you-apply/receiving-offer/***](http://www.manchester.ac.uk/study/undergraduate/applications/after-you-apply/receiving-offer/)

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. Such information will be carefully considered in advising on your medical suitability for your proposed course. Where considered appropriate we can then advise your chosen School of the need to consider any reasonable adjustments in light of the level of fitness required to complete the course.

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 you to complete the course. However, for those undertaking healthcare studies / professional programme, we need to ensure that you will be able to fulfil the competency standards of the course and of the relevant regulatory body (e.g. GMC/ GDC/ NMC/HCPC etc.) and following graduation be fit to practice within their chosen field.

In the rare case that it is decided that you are not medically fit 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 Any failure to do so may result in the offer of a place being withdrawn or reconsideration of your fitness to continue with the course.**

The information supplied by you on this questionnaire will be used to assess your medical suitability to commence your course and a certificate will be provided and forwarded to your School. The Occupational Health Service may contact you for further information / to arrange an appointment.

You can be assured that the information will remain confidential to the staff of the Occupational Health Service. The relevant School will only be informed of the functional effects of any health concerns / 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 complete all Sections** and ensure that all relevant details are included as this will help to avoid the delays involved with approaching you for further information.

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| **SECTION 1** |

**PERSONAL DETAILS:**

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| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| University User ID |

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| Family Name: Click here to enter text. | Forename: Click here to enter text. |
| Title: Click here to enter text. | Date of Birth: Click here to enter text. |
| Nationality: Click here to enter text. | Sex: Click here to enter text.  |

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| **University Term Time Address (if known)** | **Home Address** |
| Click here to enter text. | Click here to enter text. |
| Postcode: Click here to enter text. | Postcode: Click here to enter text. |
| Tel No: Click here to enter text. | Tel No: Click here to enter text. |
| Mobile: Click here to enter text. | Mobile*: if different to term time* Click here to enter text. |
| Email: Click here to enter text. | Email: *if different to term time* Click here to enter text. |

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| **GP’s Name and Address** | **Term Time** |
| Click here to enter text. | Click here to enter text. |
| Tel No: Click here to enter text. | Tel No: Click here to enter text. |

**Course Details:**

|  |  |
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| Name the course you have an offer for: | Click here to enter text. |
| Month & Year you intend to start the course: | Click here to enter text. |
| Length of course | Click here to enter text. |

**Work / Employment History:** (if applicable)

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| --- | --- | --- | --- |
| **Nature of Work** | **Employer** | **Start Date** | **Finish Date** |
| Click here to enter text. | Click here to enter text. | Click here to enter text. | Click here to enter text. |
| Click here to enter text. | Click here to enter text. | Click here to enter text. | Click here to enter text. |
| Click here to enter text. | Click here to enter text. | Click here to enter text. | Click here to enter text. |
| Have you ever had to finish or leave work on health grounds?(Please **X** as applicable) | **Yes**[ ]  | **No**[ ]  |
| If **yes**, please supply details including dates.Click here to enter text. |

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| Have you ever previously registered at a higher education college/ University for a course of study?(Please **X** as applicable) If **yes**, please supply details  | **Yes**[ ]  | **No**[ ]  |
| **Name of College / University** | **Start Date** | **Leaving Date** |
| Click here to enter text. | Click here to enter text. | Click here to enter text.  |
| If you failed to complete the course, please provide details:Click here to enter text. |

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| **SECTION 2** |

**YOUR HEALTH AND FUNCTIONAL CAPABILITIES:**

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| **1** | **Do you have problems with any of the following:-**(Please **X** as applicable) | **Yes** | **No** |
|  | 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 full details (e.g., extent of impairment, how you manage, support needs):Click here to enter text. |

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| **2.** | **Have you ever required special arrangements during your studies / work to accommodate a disability or health concern? (e.g. special equipment, extra time in exams, part-time working)?** (Please **X** as applicable) | **Yes**[ ]  | **No**[ ]  |
| If **YES** please give details: and an indication of date and duration etc.Click here to enter text. |
| **3** | **Do you have, or have you had, any of the following?**Please **X** as applicable) | **Yes** | **No** |
|  | a. | **Chronic Skin Condition?** e.g., eczema, psoriasis. Please also stipulate areas affected: Click here to enter text. | [ ]  | [ ]  |
|  | 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 including a diagnosis, an indication of date and duration etc. (e.g. when condition developed, severity, effects and treatment / medication):Click here to enter text. **How would you describe your current health status**Click here to enter text. |

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| **4** | **Have you ever been affected by:**(Please **X** as applicable) | **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 including an indication of date and duration etc. (e.g. when condition developed, severity, effects and treatment / medication): Click here to enter text. **How would you describe your current health status**Click here to enter text. |

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| **5** | **Have you ever received treatment from a psychiatrist, psychotherapist or counsellor?**(Please **X** as applicable) | **Yes**[ ]  | **No**[ ]  |
| If **YES** to any of the above please give details including an indication of dates, frequency of attendance, reason for attendance, and if treatment completed or ongoingClick here to enter text.**How would you describe your current health status**Click here to enter text. |

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| --- | --- | --- | --- |
| **6** | **Are you currently taking any medication or treatment?**(Please **X** as applicable) | **Yes**[ ]  | **No**[ ]  |
| If **YES**  please give details, including current dose:Click here to enter text. |

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| **7** | **Do you have any disability or health condition not already mentioned for which you think you may require support?**(Please **X** as applicable) | **Yes**[ ]  | **No**[ ]  |
| If **YES** to any of the above please give details:Click here to enter text. |

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| **8** | **What is your height?** | Click here to enter text. | **What is your weight?** | Click here to enter text. |

**If you would like any further advice to discuss the implications of your health in relation to your course, please contact:**

1. ***For all Undergraduate Courses:***

*Occupational Health Services, Waterloo Place, 182-184 Oxford Road, Manchester M13 9GP*

*Tel: 0161 275 2858 Fax: 0161 275 3137* waterlooocchealth@manchester.ac.uk

1. ***For Postgraduate Courses:***

*Occupational Health Services, B22 The Mill, Sackville Street, Manchester M13 9PL*

*Tel: 0161 306 5806 Fax: 0161 306 3245* millocchealth@manchester.ac.uk

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| **SECTION 3** |

**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. (**Please note that you are responsible for any fee charged).**

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| **BCG (TUBERCULOSIS):**  |
| Were you born in one of the countries listed below that have a high incidence of active TB (If yes please CIRCLE/HIGHLIGHT) | **Yes**[ ]  | **No**[ ]  |
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| --- | --- | --- | --- |
| **A – Eq** | **Er – Lib** | **Lit – Ph** | **Ro - Z** |
| Afghanistan | Eritrea | Lithuania | Romania |
| Algeria | Ethiopia | Macau (SAR of China) | Russian Federation |
| Angola | Fiji | Madagascar | Rwanda |
| Armenia | Gabon | Malawi | Sao Tome and Principe |
| Azerbaijan | Gambia | Malaysia | Senegal |
| Bangladesh | Georgia | Maldives | Sierra Leone |
| Belarus | Ghana | Mali | Singapore |
| Benin | Greenland | Marshall Islands | Solomon Islands |
| Bhutan | Guam | Mauritania | Somalia |
| Bolivia | Guinea | Micronesia | South Africa |
| Botswana | Guinea-Bissau | Moldova | South Sudan |
| Brazil | Guyana | Mongolia | Sri Lanka |
| Brunei Darussalam | Haiti | Morocco | Sudan |
| Burkina Faso | Honduras | Mozambique | Swaziland |
| Burundi | Hong Kong (SAR of China) | Myanmar (Burma) | Tajikistan |
| Cambodia | India | Namibia | Tanzania |
| Cameroon | Indonesia | Nauru | Thailand |
| Cape Verde | Iraq | Nepal | Timor-Leste (East Timor) |
| Central African Republic | Kazakhstan | Nicaragua | Togo |
| Chad | Kenya | Niger | Turkmenistan |
| China (including Taiwan) | Kiribati | Nigeria | Tuvalu |
| Congo | Korea, People’s Rep (North) | Northern Mariana Islands | Uganda |
| Congo, Democratic Republic | Korea, Republic of (South) | Pakistan | Ukraine |
| Cote d’Ivoire | Kyrgyzstan | Palau | Uzbekistan |
| Djibouti | Lao | Panama | Vanuatu |
| Dominican Republic | Latvia | Papua New Guinea | Viet Nam |
| Ecuador | Lesotho | Paraguay | Yemen |
| El Salvador | Liberia | Peru | Zambia |
| Equatorial Guinea | Libya | Philippines | Zimbabwe |

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| Please **X** as applicable: | **Yes** | **No** |
| Have you had Tuberculosis?If YES please give details of:Date Click here to enter text. Treatment received Click here to enter text. | [ ]  | [ ]  |
| In the last 12 months, have you had any of the following; unexplained weight loss, night sweats, cough lasting more than 3 weeks or coughing up blood? If YES please give details; Click here to enter text. | [ ]  | [ ]  |
| Please **X** as applicable: | **Yes** | **No** |
| Has a family member or close friend ever been diagnosed as having TB?If **YES** please give further details;Were you screened for TB following this incident? Click here to enter text. If YES please give details of investigations; Click here to enter text. What were the investigation results?; Click here to enter text. Please supply copies of investigations, treatment and results if available.  | [ ]  | [ ]  |
| To your knowledge have you had any recent contact with TB? If YES please give details; Click here to enter text. | [ ]  | [ ]  |
| Have you lived, travelled or worked abroad for more than 4 weeks in the last 5 years? If yes please answer the following questions in full:• Which country did you reside in/travel to? Click here to enter text.• What were the dates of your residence/travel? Click here to enter text.• What was the purpose of your travel? Click here to enter text.• Where did you stay, i.e. hotel/ with family or friends/other? Click here to enter text. | [ ]  | [ ]  |
| Since your return to the UK, have you developed any TB symptoms, (unexplained weight loss, night sweats, cough lasting more than 3 weeks or coughing up blood?)  | [ ]  | [ ]  |
| Since your return to the UK have you been screened for TB?If **YES** please give details: Click here to enter text.Please supply copies of investigations, treatment and results if available. | [ ]  | [ ]  |
| Do you intend to travel to any of the countries listed above for 4 weeks or more prior to commencing your university course?* If yes which countries do you intend to travel to; Click here to enter text.
* What are your proposed dates to and from dates of travel; Click here to enter text.
* What is the purpose of your travel? Click here to enter text.
* Where will you be staying, i.e. hotel/with family or friends/other? Click here to enter text.
 | [ ]  | [ ]  |
| Have you been vaccinated against Tuberculosis? | [ ]  | [ ]  |
| If **YES** please give details of date of Tuberculosis vaccination (BCG): Click here to enter text. |
| 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: Click here to enter text. | [ ]  | [ ]  |

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| **MMR (MEASLES, MUMPS AND RUBELLA) / VARICELLA (CHICKEN POX)** Please specify: |
| **I have had the following disease(s):** | **Yes** | **No** | **Don’tKnow** | **I have received the following vaccinations:** | **Yes** | **No** | **Date Received:** |
| Measles: | [ ]  | [ ]  | [ ]  | Measles: | [ ]  | [ ]  | Click here to enter text. |
| Mumps: | [ ]  | [ ]  | [ ]  | Mumps: | [ ]  | [ ]  | Click here to enter text. |
| Rubella: | [ ]  | [ ]  | [ ]  | Rubella: | [ ]  | [ ]  | Click here to enter text. |
|  | [ ]  | [ ]  | [ ]  | MMR (please note that 2 are required): | [ ]  | [ ]  | 1. Click here to enter text.2. Click here to enter text. |
| Chicken Pox: | [ ]  | [ ]  | [ ]  | Varicella: | [ ]  | [ ]  | Click here to enter text. |

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| **HEPATITIS B:** |
| Please **X** as applicable: | **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**Click here to enter text. | **Date of 2nd Dose**Click here to enter text. | **Date of 3rd Dose**Click here to enter text. | **Date of blood test**Click here to enter text. | **Result of blood test lµ/l**Click here to enter text. | **Date of Booster**Click here to enter text. |

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| **OTHER VACCINATIONS:** |
|  | **Dates Of Vaccinations:** |
|  | 1st | 2nd | 3rd | 4th | Booster |
| Pertussis (Whooping Cough) | Click here to enter text. | Click here to enter text. | Click here to enter text. | Click here to enter text. | Click here to enter text. |
| Polio | Click here to enter text. | Click here to enter text. | Click here to enter text. | Click here to enter text. | Click here to enter text. |
| Tetanus | Click here to enter text. | Click here to enter text. | Click here to enter text. | Click here to enter text. | Click here to enter text. |
| Diphtheria | Click here to enter text. | Click here to enter text. | Click here to enter text. | Click here to enter text. | Click here to enter text. |
| Meningitis ACWY | Click here to enter text. | Click here to enter text. | Click here to enter text. | Click here to enter text. | Click here to enter text. |
| Other (specify) | Click here to enter text. | Click here to enter text. | Click here to enter text. | Click here to enter text. | Click here to enter text. |

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

If for any reason you wish to discuss this further please contact:

**Undergraduate Programmes** Fliss Anderson 0161 275 2862 fliss.anderson@manchester.ac.uk

**Postgraduate Programmes** Pauline Hollinshead 0161 275 0970 pauline.hollinshead@manchester.ac.uk

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| **SECTION 4** |

**DECLARATION:**

***“I certify that my answers to the above 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.”***

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| --- | --- | --- |
| **Name:** Click here to enter text. | **Signature:**  Click here to enter text. | **Date:** Click here to enter text. |

Please complete the form electronically and e-mail it to the University of Manchester Occupational Health Service, as soon as possible but a least within a month of receipt. (2 weeks For Students applying through ‘Clearing UCAS’).

If you have to scan the questionnaire before e-mailing it please save and attach it as a **single** document.

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| **For Undergraduate applicants:** including Nursing, Midwifery, Dentistry, Oral Health Sciences , Pharmacy, Speech & Language Therapy, Healthcare Science, Audiology, Optometry, please e-mail to the Occupational Health Department 82-184 Waterloo Place, Oxford Road, Manchester M13 9GP Tel: 0161 275 2858, e-mail = waterlooocchealth@manchester.ac.uk |
| **For Postgraduate applicants:** including Dentistry, Audiology, Physician Associate, Teach First PGCE, MA Social Work, please e-mail to the Occupational Health Department B22 The Mill, Sackville Street, Manchester M13 9PL Tel: 0161 306 5806, e-mail = millocchealth@manchester.ac.uk |

The University of Manchester Occupational Health Services do not consider email to be a secure method for communicating sensitive personal data as it can be intercepted and read by third parties during transit. If you do correspond with us by email, we will take this to mean that you understand and accept this risk. If you wished to discuss an alterntive to e-mail please contcat the relevant Occupational Health Department.

**PLEASE ENSURE THAT YOU HAVE REVIEWED / COMPLETED ALL SECTIONS OF THIS HEALTH QUESTIONNAIRE BEFORE SENDING.**

**YOU ARE ADVISED TO RETAIN A COPY FOR YOUR OWN RECORDS**

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| **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 in accordance with the University of Manchester retention schedule.* 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
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| **SECTION 5** |

**CONSENT FOR FURTHER MEDICAL INFORMATION / ACCESS TO MEDICAL REPORTS ACT 1988**

In the event that you have provided us with details of a current, or past, medical condition it may be necessary to obtain additional information from your General Practitioner or Specialist. The University of Manchester cannot apply to a Doctor/Specialist who has been responsible for your care for a medical report without your consent.

1. **If you give consent:**
2. You may indicate overleaf that you wish to see the report before it is sent on to the Occupational Health Service. If so you have the right:
	1. If requested, to receive a copy of the application for a medical report.
	2. You have 21 days from that date to make your own arrangements with your doctor to see the report. If you want a printed copy your Doctor may charge you a fee.
3. If you do not indicate overleaf that you wish to see the report, you may still contact your doctor asking to see it, and (provided the report has not already been sent) you will then have 21 days to make arrangements to see it before it is sent on.
4. Your Doctor must keep a copy of the report (which you may ask to see) for 6 months afterwards.
5. **When you have seen the report you may:**
6. Ask the Doctor to change any part which you think is inaccurate or misleading.
7. Ask the Doctor to attach to the report your version on that part, if the Doctor does not agree to change it.
8. Refuse to allow the report to be sent on
9. **A doctor need not show you any part of a medical report which would:**
10. Be likely to harm your physical or mental health
11. Be likely to harm the physical or mental health of someone else.
12. Reveal the identity of a third party, other than another health professional who wants to remain anonymous.
13. Reveal the doctor’s intentions about you
14. Under the Data Protection Act 1998 you also have the right to see your own health record, i.e. all the records which your General Practitioner or Specialist is holding about you. The Occupational Health Service is not asking for a copy of all your records and the University has no right to order you to produce these. All that is being requested is a report on your current state of health as it is affecting your work and the likely predictions for the future. If you are concerned about this you should discuss the matter with your General Practitioner

It would be helpful, and will reduce the time to complete your medical assessment, if you can please complete the “Consent Form” giving the full contact details of any Specialists (medical, psychological etc.), involved in your care and include this when returning the form. This will provide the necessary informed consent for us to write for further information if considered appropriate to do so.

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| university-1 | **Occupational Health Service****The University of Manchester****www.occhealth.manchester.ac.uk** |

#### CONSENT FORM

|  |  |
| --- | --- |
| **Your Name:** | Click here to enter text. |
| **Date of Birth:** | Click here to enter text. |
| **Home Address:** | Click here to enter text. |
| **Home Telephone No:** | Click here to enter text. |
| **Mobile Telephone No:** | Click here to enter text. |
| **Email address:** | Click here to enter text. |

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| **Your GP’s Name:** | Click here to enter text. |
| **GP’s Telephone No:** | Click here to enter text. |

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| **Your Specialist’s Name:** | Click here to enter text. |
| **Address:** | Click here to enter text. |
| **Telephone No:** | Click here to enter text. |
| **Hospital No (if known):** | Click here to enter text. |

I understand my rights under the Access to Medical Reports Act 1988 and have read the guidance provided.

I hereby consent to a medical report being supplied in confidence to the University of Manchester Occupational Health Service.

**I DO** / **DO NOT \*** wish to see any medical report before it is supplied.

Signed**:** Please insert a picture of your normal signature here. This must be your normal signature scrawl NOT a typed name. Alternatively print the full document, (all section/pages), manually sign here, scan and return the fully completed document to Occupational Health by e-mail

Date: …………………………

**\***delete as appropriate