Pre-Acceptance Health Assessment – Fitness to Train Questionnaire					
SECTION 1- Your Personal Details STUDENTS ONLY					
University ID (if known):			Proposed course:		
Place offered to start when:			**Date of Birth:**		
Family/Last Name:	**Title:**		**First names:**		
Country of Origin:			**How long have you lived in the UK?**		
Home Address (including postcode)			Telephone: Mobile:	Personal Email:	
Term-time Address (including postcode)			Telephone: Mobile:	University of Salford Email:	
Name (and relationship) of contact in case of emergency:			Telephone:		
Have you ever previously registered at a higher education college/university for a course of study?				**Yes**	**No**
If YES, please provide details: Where: Start/leaving dates: If you failed to complete the course, please state why:					
Your Health and Functional Capabilities: please answer the following:				**Yes**	**No**
1	Do you have problems with any of the following:				
	a	**Mobility** - walking, using stairs, balance:			
	b	**Agility** - bending, reaching up, kneeling down:			
	c	**Dexterity -** getting dressed, writing, using tools:			
	d	**Physical Exertion** - lifting, carrying, running:			
	e	**Communication** - speech, hearing:			
	f	**Vision** - visual impairment, colour blindness, tunnel vision:			
If YES to any of the above, please give details (e.g., extent of impairment, how you manage, support needs):					

2	a	Have you ever required special arrangements at school or work to accommodate a disability, learning disorder or health problem? (e.g. special equipment, extra time in exams, part-time working)?		
	b	Have you ever been diagnosed with a learning disorder (e.g. dyslexia)		
If YES to any of the above, please give details (e.g., extent of impairment, how you manage, support needs):				
3	Do you have, or have you ever had, any of the following:			
	a	**Chronic Skin Condition** – e.g. eczema, psoriasis dermatitis:		
	b	**Respiratory Condition** – e.g asthma, cough lasting more than 3 weeks, sputum, coughing up blood;		
	c	**Neurological Disorder** – e.g. epilepsy, multiple sclerosis:		
	d	**Allergies** – e.g. latex, medicines, foods:		
	e	**Endocrine Disease** – e.g. diabetes.		
	f	**Hepatitis B/ Hepatitis C/ HIV**:		
	g	**General Health Concerns** – e.g. weight loss, night sweats, sleep disturbance		
If YES to any of the above please give details (e.g. when condition developed, severity, effects and treatment):				
4	Have you ever been affected by:			
	a	**Sudden Loss of Consciousness** - e.g. fit or seizure:		
	b	**Chronic Fatigue Syndrome/ME** - 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:				
5	Have you ever received treatment from a psychiatrist, psychotherapist or counsellor?			
If YES, please give details:				
6	Are you currently taking any medication or treatment?			
If YES, please give details:				
7	Do you have any disability or health condition not already mentioned? Does this condition cause you to require support during your employment/ education or training?			
If YES, please give details:				

8	What is your weight	**kg**	What is your height	**m**

Name -	DOB -

SECTION 2 – Your Immunisation History
STUDENTS ONLY

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.

If you have previously attended an Occupational Health service for vaccinations, please also contact them for details.

			Yes	No
1	BCG (Tuberculosis) (TB)			
	a	Have you had Tuberculosis (TB)		
If YES		When?		
		Where?		
		Treatment?		
	b	Have you ever had a chest x-ray?		
If YES		When?		
		Where?		
		Results?		
	c	Has anyone in your family or household had TB?		
If YES		Who?		
		When?		
	d	Have you lived, had regular visits abroad, or had regular visitors from abroad?		
If YES		When?		
		Where?		
	e	Have you ever coughed up blood, had a persistent cough for more than 3 weeks, had an unexplained high temperature, had night sweats or had any unexplained weight loss?		
If YES please give details:				
	f	Have you had a Mantoux test / Heaf skin test / TB blood test?		
If YES		When?		
		Where?		
		Results?		
	g	Have you been vaccinated against Tuberculosis (BCG):		
If YES		When?		
		Where?		
		Do you have a visible scar (usually located on the upper arm)		
2	Chicken Pox			
	a	Have you had Chicken Pox		
	b	Have you had Chicken Pox vaccination		

Information and Declaration

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.

Records are held in confidence by The University's Student 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. Health records will normally be kept for 7 years following graduation or withdrawal from the course.

The University of Salford 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 295 6856 or email dataprotection@salford.ac.uk

Declaration – Please read this carefully

I certify that my answers to the questions are complete, accurate and truthful and also that 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.

The information supplied by you on this questionnaire will be used to produce a certificate. This will be sent to your School as evidence of your fitness to train. I understand that it is my responsibility to notify the University immediately if my health or disability status changes in the time between the completion of this questionnaire and beginning the programme, and at any stage after I commence the programme.

I give my consent for my General Practitioner/Doctor to provide the medical staff at the University Occupational Health Service with any medical information relevant to my application.

I give my consent to undertake an Occupational Health assessment and for the administration of the blood tests and immunisations required. I understand that specific advice will be provided to me as I attend for my appointments.

I undertake to attend my Occupational Health appointments and I understand that charges, and a review of my fitness to train, may incur if I do not attend as I have agreed.

Signed: **Date:**

Students Please ensure that you have answered ALL of the questions in section 1 & 2
GP's Please complete sections 3 & 4

DO NOT SEPARATE THE FORM

Please take your completed and signed form together with your vaccination record to your General Practitioner/Doctor and request that he / she complete the enclosed GP Certificate. You will be responsible for any fee if this is required by your General Practitioner/Doctor.

After your General Practitioner/Doctor has completed your GP Certificate

Please return the whole completed Pre – Acceptance Health Screening Questionnaire to:
Student Occupational Health Services, L730 Allerton Building, Frederick Road Campus, The University of Salford, M6 6PU. Tel: 0161 295 6273

SECTION 3 - GP Certificate
YOUR DR TO COMPLETE

Dear Doctor
Your patient has been offered a place to study at The University of Salford. All prospective students undertaking a course subject to the requirements of a regulatory body e.g. GMC/ GDC/ NMC /HPC etc., are required to complete a health questionnaire to enable the University to assess their medical fitness and where appropriate consider any reasonable adjustments or additional support needs.
We would ask for your **co-operation** in verifying the health information provided by the prospective student.

Please tick the appropriate answer:		Yes	No
1	Are you the applicant's usual General Practitioner/Doctor?		
2	Are you the relative of the applicant?		
3	Do you hold the applicant's medical record?		
4	According to the records and knowledge of the applicant, do the answers to the questions in **Sections 2 and 3** appear correct, full and accurate? Please add comments below if appropriate.		
5.	How long have you held the medical records of this person?	(Date please)	
6	From what date do they commence?	(Date please)	
7a	How often has the applicant consulted you? • In the past 1 month?	(number please)	
7b	• In the previous 12 months	(number please)	

Has the applicant ever had or is experiencing:	If **Yes**, please **tick** below	If **No**, please **tick** below	If you have ticked '**Yes**', please give **details** and **dates**
Any significant physical illness/problems?			
Any episodes of depression, anxiety, stress related illness?			
Any psychotic or hallucinatory episodes?			
Any attempts to self-harm, over dose, suicide attempts, however trivial it may have seemed			
Any other psychological/personality problems, behavioural or eating disorder etc			
Any prolonged periods of illness, especially if causing time off work/college/school?			

Name -	DOB -

Comments						
5	Please provide a printout of the applicant's full immunisation history **OR** complete Question 6 as below					
6	Immunisation				Yes	No
	a	Does this applicant have a history of Tuberculosis (TB)?				
	b	Has the applicant received a BCG vaccination?				
If YES		When?				
		Has the applicant received vaccination against Hepatitis B?				
If YES please provide the following dates and details						
Date of 1st Dose	Date of 2nd Dose	Date of 3rd Dose	Date of blood test	Result of blood test lμ/l	Date of Booster	
Vaccinations	Dates Of Vaccinations:					
Measles						
Mumps						
Rubella						
MMR						
7	Are you aware of any additional medical information which may be relevant to this application? If Yes, please provide details below.					
Details:						

General Practitioner's/ Doctor's Signature:
Print Name:
Date:

Practice Stamp

Section 4 – Any Extra Information

Further Information space if required

Name -	DOB -