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|  | QMUL Malta -Occupational Health Service MaltaBarts and The London School of Medicine and DentistryTriq L-Arcisqof Pace,Victoria, VCT 2520,Gozo, MaltaE: occhealthmalta@qmul.ac.uk |

Prospective Medical Student Health Assessment **CONFIDENTIAL**

**Introduction:** Queen Mary University of London is committed to ensuring equality of opportunity for students with impairments and health conditions. It is our legal responsibility to ensure that any barriers to our courses are removed and one way in which that can be achieved is to find out about you and your requirements. We also have to be assured that we can help you practise safely in training and in employment. Now you have been offered a place on the course we wish to begin this process by asking you to complete this form.

The School will provide all reasonable support to enable students with impairments and health conditions to complete their studies. Appropriate support can be provided for almost all circumstances even if the effects of impairment or ill health are substantial. However, because of a requirement to ensure patients are not harmed through involvement in medical training, if you have a condition which would make it impossible for you to work safely with patients or to acquire the skills necessary to complete training, even with adjustments and support, then you cannot be accepted onto the undergraduate medicine course. In this circumstance, the university will endeavour to offer you a place on an alternative course. However, you should not assume that your impairment or health condition will prevent your take-up of a place and we would be pleased to speak with you at the earliest opportunity about any concerns you may have.

Please answer each of the following questions, providing brief detail on any questions answered ‘yes’. You should then complete the declaration in Section 3 and then arrange for your general practitioner, or usual doctor, to complete the Immunisation Record in Section 4 and the Doctor’s Certificate in Section 5.

Once you have completed all sections, you should then send the form using **recorded post or special delivery next day service (retaining the proof of posting receipt)**, to the **QMUL Malta Occupational Health Service, C/O Jade Dotse, Student Office, Triq L-Arcisqof Pietru Pace, Victoria, Gozo, VCT 2520, Malta.**

Alternatively, you may also send a scanned copy of this questionnaire via email to: occhealthmalta@qmul.ac.uk

Mark your envelope or email ‘Medical – In Confidence’ with your **FULL NAME AND APPLICATION NUMBER** and please **ensure you keep a copy for yourself.**

**It is important that you retain the original signed copy for yourself in case you need to refer to it at a later date. Please note, the school may need to see the original document at some stage in your studies.**

If you declare any impairment or health condition which may require us to adjust the course programme, or which may affect your fitness for work with patients, the University will contact you about this for further assessment.

**Confidentiality:** All medical and sensitive personal information you provide will be held in confidence by the University. Your immunity status will be shared with the School of Medicine and Dentistry so that they can ensure your safety when attending placements. To ensure that the correct support is in place for you when you start the course, your information may be passed to the Disability and Dyslexia Service (DDS) or medical and dental student support service.

**Data Protection Information**:

You may obtain access to your OH record by contacting the Student Office in Malta:

Barts and The London School of Medicine and Dentistry

Triq L-Arcisqof Pace,

Victoria,

VCT 2520,

Gozo, Malta

occhealthmalta@qmul.ac.uk

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| If you become a student at this College this questionnaire will form the basis of your Occupational Health (OH) record. If you do not join, your questionnaire will be destroyed. Records are held **in confidence** by the University in line with the GMC’s guidance on confidentiality  |

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| **Part A: To be completed by the Applicant**  |
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| **Section 1: Personal Details** |  |
| Family Name: | Given name(s):  |
| Date of Birth: | Gender:  |
| Title:  | QMUL Application Reference number: |
| Contact Address:  |  |
| Postcode:  |  |
| Home Phone Number:  |  |
| Mobile Number: |  |
| GP’s name and address: |  |
| Postcode:  |  |
| Telephone Number:  |  |
|  | GP Practice Stamp |
|  **Section 2: Your Health and Functional Capabilities** |  |
| Weight \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ kg  | BMI \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ (<https://www.nhs.uk/live-well/healthy-weight/bmi-calculator/>) |
| 1. Do any of the following present you with difficulty?
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| 1. **Mobility e.g. walking, running, using stairs**
 | Yes □ No □ |
| 1. **Agility** e.g., bending, reaching up, kneeling down, maintaining balance
 | Yes □ No □ |
| 1. **Dexterity** e.g. getting dressed, writing, using tools
 | Yes □ No □ |
| 1. **Physical Exertion** e.g. lifting, carrying, running
 | Yes □ No □ |
| 1. **Communication** e.g. speech, hearing
 | Yes □ No □ |
| 1. **Vision** e.g. visual impairment, colour blindness, tunnel vision
 | Yes □ No □ |
| 1. **Learning** e.g. dyslexia, dyspraxia, dyscalculia, impaired concentration
 | Yes □ No □ |
| If yes to any of the above, give details e.g. extent of impairment, any support needs or adjustments required at school work or home including supporting documentation such as dyslexia assessment etc.: |  |
| 1. Have you ever required arrangements at school to overcome barriers? E.g. equipment, extra time in exams, part-time working
 | Yes □ No □ |
| If yes, give details: |  |
| 1. Do you have any of the following?
 |  |
| 1. **Chronic skin conditions** e.g. eczema, psoriasis
 | Yes □ No □ |
| 1. **Neurological disorder**  e.g. epilepsy, multiple sclerosis
 | Yes □ No □ |
| 1. **Allergies** e.g. to latex, medicines, foods
 | Yes □ No □ |
| 1. **Endocrine disease** e.g. diabetes
 | Yes □ No □ |
| If yes, give details e.g. when condition developed, severity, effects, treatment, adjustments required at school, work or home: |  |
| 1. Have you ever been affected by:
 |  |
| 1. **Sudden loss of consciousness** e.g.fit or seizure
 | Yes □ No □ |
| 1. **Chronic fatigue syndrome** (or similar condition)
 | Yes □ No □ |
| 1. **An illness requiring more than two week’s absence from school or work**
 | Yes □ No □ |
| 1. **Mental Health problems** e.g. anxiety, depression, phobias, OCD, nervous breakdown, personality disorder, over-dose or self-harm, drug or alcohol dependency
 | Yes □ No □ |
| 1. **An eating disorder** e.g. bulimia, anorexia nervosa, compulsive eating
 | Yes □ No □ |
| If yes, give details: |  |
| 1. Have you ever been assessed or treated by a psychiatrist, psychotherapist or counsellor?
 | Yes □ No □ |
| If yes, give details e.g. when, reason, outcome: |  |
| 1. Are you currently taking any medication or treatment
 | Yes □ No □ |
| If yes, give details |  |
| 1. Do you have any impairment or health condition not already mentioned which you think may require support or adjustments during your education?
 | Yes □ No □ |
| If yes, give details |  |
| **Section 3: Infectious Diseases** |  |  |
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| Tuberculosis |  | Details, including dates |
| Have you had tuberculosis or any exposures to tuberculosis e.g. close family and social contacts with TB within the last two years  | Yes □ No □ |  |
| Have you lived in the UK (excluding holidays) for the last 12 months?  | Yes □ No □ | If No, please state in which country you have been living and for how long  |
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| **Section 4: Declaration** |  |
| ***Please tick the relevant boxes and sign below*** |  |
| The information I have provided on my health is **correct** to the best of my knowledge and belief.  | □ |
| I consent to my information being held and processed by the School Of Medicine and Dentistry as described above under ‘Data Protection Information’  | □ |
| If you have indicated that you have a disability or specific learning difficulty, (e.g. dyslexia): I consent to my contact details being passed to the College’s Disability and Dyslexia Service so that they can contact me directly. | □ |
| Signed: Date: |  |

**Part B: IMMUNISATION RECORD: TO BE COMPLETED BY THE APPLICANT’S GENERAL PRACTITIONER (GP)**

GP Practice Stamp

Your patient should have provided you with a letter to accompany this form, please refer to this for more information. ***PLEASE NOTE. A medical examination is not required.***

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| 1. Are you the applicant’s usual doctor?
 | Yes □ No □ |
| If **no**, please provide details  |  |
| 1. Are you a relative of the applicant?
 | Yes □ No □ |
| If **yes,** please provide details |  |
| 1. Do you hold the applicant’s medical record?
 | Yes □ No □ |
| If **no,** please provide details  |  |
| 1. According to your records and knowledge of the applicant, do the answers to questions in Part A, Section 2 appear correct? (please add any comments below, if appropriate)
 | Yes □ No □ |
| 1. Are you aware of any additional medical information which may be relevant to this application?
 | Yes □ No □ |
| If **yes** please provide detail |  |

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| **Has the student had Chickenpox?**  | Yes □ No □ | *If unsure whether the student has had chickenpox,* *Answer NO*  |
| **Primary Hepatitis B Vaccination Course**  | Date of 1st Dose | Date of 2nd Dose | Date of 3rd Dose | Antibody date and result, if known  | 5 year booster date  | *Send a copy* *of the antibody result with this form, if available* |
| **MMR** ***OR single Vaccines*** ***If applicable******OR results of Serological tests for measles and rubella if available*** | Date of 1st Dose | Date of 2nd Dose | ***All students MUST have 2 doses of MMR****, unless they have serological evidence* *of immunity to* *measles & rubella If single doses of measles, mumps,* *rubella given please indicate clearly with* *dates* *If serological evidence please enclose copy of lab report*  |
| **BCG** | Date of Vaccine | *Enter exact date* *only from record or e.g. school TB* *vaccination service* *Scar check may be undertaken on commencement of studies.* |
| **Mantoux Test /** **Chest x-ray**  | Date of Test | Result? | If available |
| **Hepatitis B** | Date of Test | Result? |  |
| **DTP (tetanus, diphtheria and polio)** | Date of Test | Result? |  |
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| Doctor’s Signature: Date: |  |