

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

- |                          |                          |                       |
|--------------------------|--------------------------|-----------------------|
| <input type="checkbox"/> | <input type="checkbox"/> | Back problems         |
| <input type="checkbox"/> | <input type="checkbox"/> | Joint problems        |
| <input type="checkbox"/> | <input type="checkbox"/> | Foot or leg problems  |
| <input type="checkbox"/> | <input type="checkbox"/> | High blood pressure   |
| <input type="checkbox"/> | <input type="checkbox"/> | Rheumatic Fever       |
| <input type="checkbox"/> | <input type="checkbox"/> | Heart complaint       |
| <input type="checkbox"/> | <input type="checkbox"/> | Allergies of any kind |
| <input type="checkbox"/> | <input type="checkbox"/> | Varicose veins        |
| <input type="checkbox"/> | <input type="checkbox"/> | Sight defects         |
| <input type="checkbox"/> | <input type="checkbox"/> | Head injury           |

Yes No

- |                          |                          |   |
|--------------------------|--------------------------|---|
| <input type="checkbox"/> | <input type="checkbox"/> | Severe or recurrent headaches                     |
| <input type="checkbox"/> | <input type="checkbox"/> | Epilepsy, fainting attacks, fits or blackouts     |
| <input type="checkbox"/> | <input type="checkbox"/> | Diabetes or kidney complaints                     |
| <input type="checkbox"/> | <input type="checkbox"/> | Asthma, bronchitis, pleurisy or lung disease      |
| <input type="checkbox"/> | <input type="checkbox"/> | A substance related disorder, dependence or abuse |
| <input type="checkbox"/> | <input type="checkbox"/> | Mental illness requiring psychiatric care         |
| <input type="checkbox"/> | <input type="checkbox"/> | Are you on medication?                            |
| <input type="checkbox"/> | <input type="checkbox"/> | Other, please specify                             |

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:

  
  

**Doctor  
Signature:**

Date:

Doctor/Practice Stamp: