UCOL
Universal College of Learning
Te Pāe Mātauranga Ki Te Ao

UCOL is a polytechnic under the Education Act.

Health Declaration Form

A declaration of an applicant's past and present health status is a requirement for entry into this programme. While health problems are not a barrier to entering a programme, it is important that the Programme Leader is aware of them and can discuss them fully with you. Please answer all questions in this section, then make an appointment with your Doctor who should complete the medical report section.

THE INFORMATION GIVEN 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
☐	☐	2	Joint problems
☐	☐	3	Foot or leg problems
☐	☐	4	High blood pressure
☐	☐	5	Rheumatic Fever
☐	☐	6	Heart complaint
☐	☐	7	Allergies of any kind
☐	☐	8	Varicose veins
☐	☐	9	Sight defects
☐	☐	10	Head injury
☐	☐	11	Severe or recurrent headaches
☐	☐	12	Epilepsy, fainting attacks, fits or blackouts
☐	☐	13	Diabetes or kidney complaints
☐	☐	14	Asthma, bronchitis, pleurisy or lung disease
☐	☐	15	A substance related disorder, dependence or abuse
☐	☐	16	Mental illness requiring psychiatric care
☐	☐	17	Are you on medication?
☐	☐	18	Other, please specify _____

Signature of applicant

Date

Day | Month | Year

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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