**Confidential**

**Undergraduate Students Health Declaration**

Congratulations in accepting a pre-registration healthcare course at the University of Glasgow. All applicants for pre-registration health care courses are required to undertake occupational health screening, you are therefore required to complete this health declaration.

**Once completed, you can return the form with supporting documents:**

* **Electronically by email to** [**ohu@admin.gla.ac.uk**](mailto:ohu@admin.gla.ac.uk)
* **Post: Occupational health, University of Glasgow, 63 Oakfield Avenue, Glasgow, G12 8LP**

The purpose of this health needs assessment is to assess whether you have any health condition(s) that could affect your ability to undertake your training and to ensure that your health is not placed at risk during your studies. It will assist in establishing whether you may require specific adjustments in accordance with the disability [provision of the Equality Act 2010. You should not assume that your impairment or health condition will prevent you from studying. All information provided shall be held and treated in confidence by the University of Glasgow, Occupational health department, the school of study shall only be informed of effects of a health condition or impairment if applicable to your educational needs or patient safety, and of recommendations of support and reasonable adjustments if applicable.

**Please complete all sections fully in black ink/print. It is preferred to use the dropdown lists. Incomplete health questionnaires shall be returned, which may delay the screening process. All immunisation/blood serological evidence must be emailed or posted to occupational health along with your completed health declaration. Please use the drop-down lists to assist with completion.**

**Course of study:** Choose an item.

|  |  |  |  |
| --- | --- | --- | --- |
| **Surname:** | **Given Name:** | | **Prefer to be known as:** |
| **Date of Birth:** | | **Country of Birth:** | |
| **Email address:** | | **Contact telephone Number:** | |
| **Address:** | | | |
| **If you are an overseas student, please provide country of origin:** | | | |

**Health Information**

**If you answer yes to any question, please ensure that you provide additional information at the end of section 2 in the free text box.**

**Do you or have you ever:**

|  |  |
| --- | --- |
| Had a physical or mental disability or condition which has a substantial effect on your ability to carry out normal day to day activities, or impair your mobility or manual dexterity? | Choose an item. |
| Problems with your vision in either eye not corrected by glasses or contact lenses? | Choose an item. |
| Difficulty with your hearing? | Choose an item. |
| Suffered from any respiratory ailments? (e.g. asthma/COPD) | Choose an item. |
| Any known allergies? | Choose an item. |

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| Any skin conditions? | Choose an item. |
| Do you have an allergy to latex? | Choose an item. |
| Suffered from any mental health disorder, including eating disorders, or attempted self-harm | Choose an item. |
| Suffered from sudden loss of consciousness e.g. fits, faints, blackouts? | Choose an item. |
| Taking any medication? | Choose an item. |
| Are you currently having or waiting for investigations, treatment, or medication for any condition, including those that may not have a confirmed diagnosis? | Choose an item. |
| Diagnosed with any neurodiverse conditions? | Choose an item. |
| Have any other medical conditions, not already mentioned, which may affect you studying or attending placements? If yes, please provide details: | Choose an item. |
| Please provide any additional detail if you have answered yes to any question, or use this space to provide additional information that you believe shall be useful for occupational health to be aware of: | |

**Immunisation History**

**It is important to ensure that you provide documented evidence of your immunisation history and/or blood serology. If you do not provide evidence, we will not be able to complete your health review until all relevant information is provided. Please ensure all evidence submitted has your name and date of birth on the document.**

**Measles, Mumps, Rubella Vaccine (MMR)**

**Evidence of 2 doses of MMR vaccine or single dose vaccines is required, alternatively, you may have evidence of serology following a blood test**. **Please ensure your evidence is included.**

|  |  |
| --- | --- |
| Have you received MMR vaccine? If yes provide dates, enter date as (dd/mm/yyyy) | Choose an item. |
| Date of dose 1 MMR vaccine? |  |
| Date of dose 2 MMR vaccine? |  |

**Varicella (chickenpox) History:**

Please indicate if you have suffered from chickenpox or shingles within your life. If you have not had chickenpox or shingles, or you have suffered from these diseases in a non-temperate country then Varicella blood serology may be required. If the blood test result indicates that you are not immune to Varicella, you may be advised to receive the vaccine (2 doses).

|  |  |
| --- | --- |
| Have you ever suffered from chickenpox or shingles? | Choose an item. |
| If yes, in which country were you living? |  |

**Hepatitis B Vaccine**

**Please provide evidence of receiving the vaccine that includes dates and/or blood test results.**

|  |  |
| --- | --- |
| Have you received Hepatitis B vaccine? If yes provide dates, enter date as (dd/mm/yyyy) | Choose an item. |
| Date of dose 1 vaccine? |  |
| Date of dose 2 vaccine? |  |
| Date of dose 3 vaccine? |  |
| Date of dose 4 vaccine? |  |

**Tuberculosis (TB) screening**

Please answer all questions, and if you have received BCG vaccine, include evidence.

**Do you have or have you recently had any of the following symptoms:**

|  |  |
| --- | --- |
| Persistent coughing lasting more than two weeks? | Choose an item. |
| Coughing up blood? | Choose an item. |
| Unexplained weight loss? | Choose an item. |
| Night sweats? | Choose an item. |

|  |  |
| --- | --- |
| Have you lived outside of the UK for 3 months or more during the last 5 years, or do you intend to live outside of the UK for 3 months or more prior to commencing your course> If yes, provide details of countries and dates: | Choose an item. |
| Have you ever been diagnosed with TB, if yes provide detail: | Choose an item. |
| Have you been in close contact with anyone found to be suffering from TB in the last 3 years? If yes provide details: | Choose an item. |
| Have you ever received BCG vaccine? If yes, provide details, including date: | Choose an item. |
| Please provide further detail that you feel may be relevant for occupational health to be aware of: | |

**Declaration**

I confirm that the information provided on this form is accurate and complete to the best of my knowledge. I understand that any false information or deliberate omission may impact my student study status. I acknowledge that my medical details will not be shared with anyone outside of occupational health without my consent. If I do not provide immunisation evidence or attend scheduled appointments with Occupational Health, the school will be informed of any outstanding requirements that prevent clinical clearance.

|  |  |
| --- | --- |
| **Signature (can be electronic)** | **Date of signature:** |

**Confidentiality**

The information provided to occupational health is confidential and shall not be disclosed to any other person(s) without your consent. The University of Glasgow is an equal opportunities establishment, seeking to promote equality in the University. The University of Glasgow shall not discriminate against those who have a disability but seek to limit the impact of the disability by fulfilling its duties specified in the Equality Act 2010. Occupational health may contact you or offer you an appointment if considered necessary and may recommend reasonable adjustments where applicable.

The decision about whether it would be reasonable to accommodate a particular adjustment is the responsibility of the University of Glasgow considering their legal obligation.

**Consent for blood testing and immunisations.**

Blood borne viruses such as Hepatitis B, Hepatitis C and HIV are transmitted if there is potential exposure to infected blood products, transmission can occur from health care worker to patient or vice versa. To prevent risk to patients and to comply with the Health and Safety at Work Act (HSWA) 1974, employees, employers and the self-employed have specific duties to protect so far as reasonably practicable, those at work and others who may be affected by their work activity, such as contractors, visitors, and patients. Central to health and safety legislation is the need for employers to assess the risks to staff and others. The Control of Substances Hazardous to Health (COSHH) Regulations 2002 require employers to assess the risks from exposure to hazardous substances, including pathogens (called biological agents in COSHH), and bring into effect the measures necessary to protect workers and others from those risks as far as reasonably practical.

All new staff/students entering the NHS are required to have blood test from blood borne viruses – Hepatitis B, Hepatitis C & HIV. If you decline consent, the relevant school of medicine/dentistry/nursing shall be informed, who shall be responsible to determine your suitability to continue in your course of study.

If you believe that you may have had exposure to any blood borne virus, you should discuss with the clinician at the time of your screening prior to any testing being conducted.

You may require additional blood tests depending on your screening assessment e.g. IGRA blood test, Varicella testing. Blood testing requires a small sample of blood to be taken from a vein.

**Complete as applicable:**

**I consent to:**

|  |  |
| --- | --- |
| blood testing for HIV | Choose an item. |
| Blood testing for Hepatitis C | Choose an item. |
| Blood testing for Hepatitis B | Choose an item. |
| If applicable, blood testing for Varicella | Choose an item. |
| If applicable, blood testing for TB screening | Choose an item. |
| **Signature (can be electronic)** | **Date of signature:** |

|  |  |
| --- | --- |
| I do **NOT** consent to any blood testing |  |
| **Signature (can be electronic)** | **Date of signature:** |

If you do not consent to blood testing, the school will be informed of your decision to withhold consent. This will include details of the outstanding requirements that must be met for clinical clearance.