

## ULSTER UNIVERSITY

### DECLARATION OF HEALTH

#### CHECKLIST FOR SUBMISSION OF DECLARATION OF HEALTH FORM

**Please use the tick list below to ensure you have included all the required documentation before submitting your form.**

**Please tick boxes to confirm that you have enclosed all requisite information:**

- ☐ Completed Health Declaration form with all sections completed and application signed.
- ☐ Certified copy of your vaccination record provided by your Health Centre OR Immunisation record on Page 3 of the Health Declaration completed and stamped by your Health Centre.

**EMAIL THE COMPLETED FORM TOGETHER WITH THE VACCINATION RECORD To:**

**[a.mullan@ulster.ac.uk](mailto:a.mullan@ulster.ac.uk)**

**T: +44 28 7167 5925**

## DECLARATION OF HEALTH



The information you provide on this form will remain confidential to the Occupational Health Service although appropriate advice can be provided, with consent, to your academic department on your medical suitability for your chosen course. Information is stored under the Data Protection Act. If you have a disability, long-term medical condition or a mental health concern, there is confidential support within the University. Contact Disability Services within Student Support on the appropriate campus.

**PLEASE COMPLETE IN BLOCK LETTERS:** Please note we will use your home address for correspondence.

### I **PERSONAL INFORMATION**

|                     |                    |                            |
|---------------------|--------------------|----------------------------|
| Course applied for  |                    |                            |
| Proposed entry date |                    | Date of Birth              |
| Full Name           |                    |                            |
| Contact No          | Home:              | Mobile:                    |
| Home Address        |                    |                            |
| Email Address       |                    | University email if known: |
| Doctor's Details    | Name:<br>Phone No: | Address:                   |
| Next of Kin         | Name:              | Tel:                       |

### PREVIOUS SICKNESS ABSENCE: (IF APPLICABLE)

Have you lost time from work or school because of illness during the past 2 years?

Yes No  
**DD**

Please give details:

| Length of Absence | Reason for Absence |
|-------------------|--------------------|
|                   |                    |

### DECLARATION:

I certify that all the information given on this form is complete and accurate to the best of my knowledge, and 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 my course of study being terminated.
- failure to complete a full programme of immunisation or to provide any relevant documentation requested could exclude me from undertaking placements and thus affect my continuation of the course.

I hereby give my consent for Occupational Health, if necessary, to seek reports from my doctor and/or specialist about my conditions, and understand that any information received will be treated in confidence.

I consent to all necessary blood tests.

Signature of Applicant.....

Date .....

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### YOUR VACCINATION HISTORY

You must complete this list of immunisations you have received **and provide a printout showing evidence of these.** This information may be available from your childhood vaccination book, school records or GP Practice. **(GP Receptionist or Practice Nurse should be able to provide a printout of your vaccinations.)**

NAME ..... DOB..... COURSE.....

| Vaccination                    | Date Given | Given by: | Result |
|--------------------------------|------------|-----------|--------|
| Mantoux                        |            |           |        |
| BCG                            |            |           |        |
| Varicella Serology             |            |           |        |
| Varicella (1)                  |            |           |        |
| Varicella (2)                  |            |           |        |
| MMR Serology                   |            |           |        |
| MMR (1)                        |            |           |        |
| MMR(2)                         |            |           |        |
| Meningococcal C (MenC)         |            |           |        |
| Hep B (1)                      |            |           |        |
| Hep B (2)                      |            |           |        |
| Hep B (3)                      |            |           |        |
| Hep B (Booster)                |            |           |        |
| Hep B (Serology)               |            |           |        |
| Hep B 1 2 <sup>nd</sup> Course |            |           |        |
| Hep B 2 2 <sup>nd</sup> Course |            |           |        |
| Hep B 3 2 <sup>nd</sup> Course |            |           |        |
| Hep C (Serology)               |            |           |        |
| HIV (Serology)                 |            |           |        |
| Flu Vaccine                    |            |           |        |

PLEASE  
ENSURE YOU  
ATTACH  
EVIDENCE OF  
ALL  
VACCINATIONS  
RECEIVED WITH  
THIS FORM

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Please answer the following questions by ticking the appropriate yes/no box. If the answer is yes please give details in the space provided, continuing on a separate page if necessary.

### YOUR FUNCTIONAL CAPABILITIES

| All questions MUST be answered                                                                                                                                                                                                        | Yes | No | If Yes, give details in in this column using a separate line if necessary. |
|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-----|----|----------------------------------------------------------------------------|
| Are you at present, receiving any treatment or regular medication supervised by your doctor?                                                                                                                                          |     |    |                                                                            |
| Have you ever received medication, seen a doctor, therapist, counsellor or been admitted to hospital or treated for the following:                                                                                                    |     |    |                                                                            |
| Mental Health problems e.g. anxiety, phobias, bi-polar disorders, psychosis, schizophrenia, nervous breakdown, depression, overdose or self-harm, obsessive compulsive disorder, autism or related disorders or personality disorder? |     |    |                                                                            |
| Eating disorders e.g. bulimia, anorexia nervosa, compulsive eating?                                                                                                                                                                   |     |    |                                                                            |
| Use of illegal/recreational drugs or alcohol/substance misuse problems?                                                                                                                                                               |     |    |                                                                            |
| Musculoskeletal problems (such as arthritis, pains in arms or legs, neck or back pain)?                                                                                                                                               |     |    |                                                                            |
| Cancer or immune-suppression due to an illness or taken high dose steroid or chemotherapy within the past year?                                                                                                                       |     |    |                                                                            |
| Do you have problems with any of the following:                                                                                                                                                                                       |     |    |                                                                            |
| Mobility e.g. walking, using stairs, balance?                                                                                                                                                                                         |     |    |                                                                            |
| Agility e.g. bending, reaching up, kneeling down?                                                                                                                                                                                     |     |    |                                                                            |
| Dexterity e.g. getting dressed, writing, using tools?                                                                                                                                                                                 |     |    |                                                                            |
| Physical Exertion e.g. lifting, carrying, running?                                                                                                                                                                                    |     |    |                                                                            |
| Communication e.g. speech, hearing?                                                                                                                                                                                                   |     |    |                                                                            |
| Vision e.g. visual impairment, colour blindness, tunnel vision, or any impairment that could not be corrected by wearing spectacles?                                                                                                  |     |    |                                                                            |
| Learning e.g. Do you have dyslexia, dyscalculia or dyspraxia?                                                                                                                                                                         |     |    |                                                                            |
| Have you ever required special arrangements at school or work to accommodate a disability or health problem e.g. special equipment, extra time in exams, part-time working?                                                           |     |    |                                                                            |
| Have you had or do you anticipate difficulty doing overnight or 12-hour shifts?                                                                                                                                                       |     |    |                                                                            |

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| <b>HEALTH CAPABILITIES</b>                                               |     |    |                                                                            |
|--------------------------------------------------------------------------|-----|----|----------------------------------------------------------------------------|
|                                                                          | Yes | NO | If Yes, give details in in this column using a separate page if necessary. |
| Have you suffered from asthma, bronchitis or other respiratory problems? |     |    |                                                                            |
| <b>Do you have, or have you had, any of the following:</b>               |     |    |                                                                            |
| Allergies e.g. latex, medicines, foods?                                  |     |    |                                                                            |
| Neurological Disorder e.g. epilepsy, multiple sclerosis, seizures?       |     |    |                                                                            |
| Sudden loss of consciousness e.g. recurrent faints?                      |     |    |                                                                            |
| Endocrine Disease e.g. Diabetes?                                         |     |    |                                                                            |
| Chronic Skin Condition e.g. eczema, psoriasis?                           |     |    |                                                                            |
| Chronic Fatigue Syndrome or similar condition?                           |     |    |                                                                            |
| Blood Borne Virus Infection e.g. Hep B/Hep C / HIV?                      |     |    |                                                                            |
| Chickenpox?                                                              |     |    |                                                                            |
| Tuberculosis (TB)?                                                       |     |    |                                                                            |

  

| <b>TUBERCULOSIS</b>                                                                                                                                                   |  |  |                                     |
|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|--|-------------------------------------|
| Weight Loss                                                                                                                                                           |  |  |                                     |
| Fever                                                                                                                                                                 |  |  |                                     |
| Night Sweats                                                                                                                                                          |  |  |                                     |
| Cough for more than 3 weeks                                                                                                                                           |  |  |                                     |
| Have you been in close contact with TB                                                                                                                                |  |  |                                     |
| <b><u>This link</u></b> gives a table of 30 TB high burden countries'<br><br>Have you travelled to any of these countries for more than 3 months in the last 2 years? |  |  | Please specify the country visited! |

If you have any medical conditions or disabilities not mentioned above, please give details:

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Should you have any queries regarding the completion of the Health Declaration Form or the vaccination programme, please telephone 028701 23350.