## Occupational Health Service

**Email:** [**ohenquiries@uhb.nhs.uk**](mailto:ohenquiries@uhb.nhs.uk)

**Telephone: 0121 371 7170**

### Pre-Course Health Questionnaire

The information you disclose in this questionnaire will remain confidential to the Occupational Health Service and will be used only to assess your fitness for your proposed course. You will be responsible for disclosing medical information to the University. Reasonable adjustments may be made by the University for medical conditions and/or disabilities.

Your programme manager and the Admissions office will only receive an opinion as to your fitness for the course. The information you give will be stored on the dedicated Occupational Health electronic record system and will be treated in strictest confidence by the Occupational Health Service in compliance with the General Data Protection Regulations (2016) unless explicit consent is given for further disclosure. In accordance with these regulations, you may have access to your records at any reasonable time. If you require a copy of any part of your record, this will only be supplied upon written request, which may incur a cost. In some cases, it may be necessary to ask you to attend a health interview.

**Please send copies of documentary evidence. DO NOT SEND ORIGINALS.**

**We would recommend you retain copies of all completed forms for your own records.**

You will only be contacted if there is a need for clarification with your health clearance.

**PLEASE RETURN THE COMPLETED HEALTH DECLARATION AND IMMUNISATION RECORD (separate documents) to** [**ohenquiries@uhb.nhs.uk**](mailto:ohenquiries@uhb.nhs.uk)

| **Name and Address**: | **Telephone/Email Contact Information and Course Details** |
| --- | --- |
| **Salutation (e.g. Dr/Mr/Mrs/etc.):** | **Home Telephone:** |
| **Surname:** | **Mobile:** |
| **Forename:** | **Email:** |
| **Date of Birth:** | **Proposed Course:** |
| **Country of Birth:** | **Start Date of Course:** |
| **Address:**  **Post Code:** |  |

If you answer ‘yes’ to any of the questions (1 – 19), please give details in the space provided, including: treatment given, hospital admissions, time required off work/school, and any effect on your work, study or leisure activities. Please also indicate if the problem is still current, or now resolved.

***Failure to give adequate information may delay your health clearance.***

|  | Do you or have you ever had? | Yes/No | Dates/Details/Current/Resolved |
| --- | --- | --- | --- |
| 1 | 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? |  |  |
| 2 | Problems with your vision in either eye not  corrected by glasses? |  |  |
| 3 | Difficulty with your hearing? |  |  |
| 4 | An injury or disease requiring treatment of any kind? |  |  |
| 5 | Suffered from any chest ailments?  (asthma/bronchitis) |  |  |
| 6 | Any skin condition?  (eczema/psoriasis/dermatitis) |  |  |
| 7 | Any known allergies? |  |  |
| 8 | Suffered from epileptic fits, faints or blackouts? |  |  |
| 9 | Are you taking or have you taken prescribed medication during the last 2 years? |  |  |
| 10 | Evidence of infection with Hepatitis B, Hepatitis C or HIV? |  |  |
| 11 | Suffered from any mental health disorder? |  |  |
| 12 | Taken a drug overdose, tried to harm yourself or attempted suicide? |  |  |
| 13 | Suffered from any illness requiring psychotherapy/counselling in the last five years? |  |  |
| 14 | Suffered from an eating disorder of any kind? |  |  |
| 15 | Learning disabilities such as dyslexia? |  |  |
| 16 | Are you attending, or waiting to attend your GP or hospital for treatment or surgery? If yes, give a brief outline why. |  |  |
| 17 | Any other medical problems, not already mentioned on this form, which may affect your course in any way? |  |  |
| 18 | Do you have, or have you recently had any of the following: |  |  |
|  | Persistent coughing lasting more than two weeks? |  |  |
|  | Coughing up blood? |  |  |
|  | Unexplained weight loss? |  |  |
|  | Unexplained fever? |  |  |
|  | Night sweats? |  |  |
| 19 | Have you lived outside of the UK for three months or more during the last 12 months, or do you intend to live outside of the UK for 3 months or more prior to starting this course? |  |  |
| 20 | Have you ever been diagnosed with Tuberculosis? |  |  |
| 21 | Have you been in close contact with a friend or relation found to be suffering from Tuberculosis in the last two years? |  |  |

### All Applicants Must Sign Declaration

* I understand the purpose of the pre-course health questionnaire and declare that the information given within this document is true and complete to the best of my knowledge. Where necessary, I agree that the Occupational Health Service may obtain screening and immunisation details as required to assist in the assessment of my fitness for the course.
* I understand that failure to disclose information may be detrimental to my health and could affect my student status leading to a termination of my enrolment as a student.
* I give my consent for my Immunisation and Vaccination history to be released to University College Birmingham. I understand and agree that this information will need to be released to Occupational Health staff at NHS Trusts due to course requirements and future employment for confirmation of vaccinations and antibody status.
* I give my consent for the Occupational Health Service to advise the University where it relates to, or impacts on, my fitness to practise. I understand the Occupational Health Service may also advise the University of any adaptations, considerations or restrictions that may be required.

**Please note – If your health status changes in any way following the completion of this health questionnaire, you MUST contact our Occupational Health Service in writing notifying us of the changes in your health.**

**Please sign below when you have read, understood and accepted the declaration.**

#### Signature:

#### Date:

#### Print Name:

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## Immunisation History Record

* All students on courses which have a clinical component must prove that they have been immunised against Rubella, Measles and Tuberculosis and are advised to be immunised against Hepatitis B.
* Dental Surgery and Dental Hygiene and Therapy students must be immunised against Hepatitis B and additionally require validated blood tests for HIV Screen, Hepatitis C Antibody Screen and Hepatitis B Surface Antigen.

You may consult with your GP to complete the Immunisation History Record, but they are not obligated to do so. Below are examples of websites that can be used as a resource:-

|  |  |  |
| --- | --- | --- |
| BUPA: | [Link to BUPA website](http://www.bupa.co.uk/facilitiesfinder) | |
| MASTA Travel Clinic: | [Link to MASTA Travel Health website](http://www.masta-travel-health.com/) | |
|  |  |  |

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#### IMMUNISATION HISTORY RECORD

#### TO BE COMPLETED BY YOUR HEALTH CARE PROFESSIONAL

**Name: Date of Birth:**

**MMR**

Documentation of two MMR vaccines is required. If you cannot produce this documentation a blood test for Rubella and Measles must be completed and a positive result obtained. Copy of blood test result to be attached.

| Vaccination | Date Given | Signature of Doctor/Nurse(Verifying information) |
| --- | --- | --- |
| MMR (1) |  |  |
| MMR (2) |  |  |

#### Hepatitis B

Healthcare students are advised to complete a full course of Hepatitis B vaccinations. Following this, a Hepatitis B Surface Antibody blood test is also advised. This immunisation/testing schedule is necessary for Dental Surgery and Dental Hygiene and Therapy students and should be undertaken prior to admission. Copy of blood test result to be provided when available.

| Vaccination | Date Given | Signature of Doctor/Nurse(Verifying information) |
| --- | --- | --- |
| Hepatitis B (1) |  |  |
| Hepatitis B (2) |  |  |
| Hepatitis B (3) |  |  |
| Hepatitis B (4) (if required) |  |  |
| Hepatitis B Booster (if required) |  |  |

#### BCG

If required, this will be provided after admission

| Vaccination | Date Given | Signature of Doctor/Nurse(Verifying information) |
| --- | --- | --- |
| BCG Vaccine |  |  |
| BCG Scar visible |  |  |

#### History of Chicken Pox:

If no history of chicken pox then a Varicella blood test is required (attach copy of result).

|  |
| --- |
| Dental Surgery and Dental Hygiene and Therapy Students onlyadditionally require:Validated blood tests for HIV Screen, Hepatitis C Antibody Screen and Hepatitis B Surface Antigen.Copies of validated blood test results to be attached. Please read guidance form below as your blood test results will not be accepted if not validated. |

### Guidance for Clinical Undergraduate Immunisation Requirements

The Immunisation Record Form is for your health care professional to complete.

We follow the guidance for new healthcare workers from the Department of Health (students engaged on clinical placements are considered as healthcare workers):

[Link to guidance document provided by Department of Health](https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/382152/health_clearance_tuberculosis_hepatitis_hiv.pdf)

It is important for applicants for Nursing and Physiotherapy to commence your vaccination schedule as soon as you accept the offer of a place, as it can take over 6 months to complete.

Prospective students are financially responsible for all vaccinations and blood tests.

#### MMR vaccines:

Either documentation of two MMR vaccines or blood test results for Rubella and Measles indicating immunity are required.

If your Rubella or Measles blood test results do not show immunity, documentation of two MMR vaccines will be required. No further blood tests will be required once you have received the two doses of MMR vaccine.

#### Hepatitis B vaccines:

A Hepatitis B Surface Antigen blood test is required prior to administration of the vaccine to screen for infectivity.

We recommend you follow the standard vaccination schedule, 0, 1 and 6 months. A Hepatitis B Surface antibody blood test will then be required approx. 8 weeks after completion of the course.

If you complete an accelerated schedule of vaccination, a fourth dose of vaccine will be required one year after starting the course. Only after this fourth dose is the course complete and at this time we would recommend the Hepatitis B Surface antibody blood test be done.

A Hepatitis B Surface antibody result of >100 miu/ml is evidence of satisfactory immunity.

#### BCG vaccination:

If a BCG scar is visible then a history of BCG vaccination is assumed. This is to be documented by your health care professional.

If you have no BCG scar and no documented evidence of BCG vaccine administration then you should be vaccinated.

A Mantoux skin test will be administered first to rule out prior exposure to Tuberculosis. If you have a negative result from the Mantoux skin test you will require BCG vaccination.

#### Chicken Pox:

Indicate if you have had chicken pox. If you have not had chicken pox then a Varicella blood test is to be completed. If the Varicella blood test indicates you are not immune to chicken pox it is recommended you receive the vaccine.

### Validated blood tests:

**These tests must state they are an “identified validated sample”. This means that the person taking the blood must check your identity and affirm on the blood test result report that this result is an identified validated sample.**