



# Medical Information Form

**Confidential**

IF YOU HAVE ANY QUESTIONS ABOUT THIS FORM OR WISH TO DISCUSS ITS CONTENTS IN MORE DETAIL  
PLEASE CONTACT THE UNIVERSITY CO ORDINATOR FOR HEALTH & COUNSELING  
TELEPHONE : +44 208 332 8208 email:colest@richmond.ac.uk

This form is a required part of the Admissions procedure. It must be completed in full by the student and by a licensed medical physician. The form must be submitted prior to starting a course. Students who do not complete a Medical Information Form prior to arrival will be required to have the form completed on arrival. Please note : Medical Physicians may make a charge for medical examinations. The information on this form will provide the basis for your personal confidential medical records kept by the University Health Service.

*PLEASE PRINT ALL INFORMATION CLEARLY*

TO BE COMPLETED BY THE APPLICANT:				FAMILY NAME:									
DATE OF BIRTH	DAY	MONTH	YEAR	FIRST NAME:									
NATIONALITY:								RELIGION (OPTIONAL)					
WHEN DO YOU PLAN TO JOIN THE UNIVERSITY				FA	SP	SU	20 _ _		FEMALE	MALE			
NAME AND ADDRESS OF A PERSON WHO CAN BE CONTACTED IN AN EMERGENCY:													
FAMILY NAME:								RELATIONSHIP TO YOU:					
ADDRESS:													
TELEPHONE:								FAX:					
PERSONAL STATEMENT: I certify that the information contained in this form and reported to the medical physician is true and complete. No materials have been withheld or omitted and I understand that this information will be made available to the University Health Service.													
STUDENT SIGNATURE:								DATE:					

## *Meningitis Statement*

Immunization against meningitis (A & C) is recommended by the British Government Health Authorities for all students starting university. Although meningitis and septicemia are quite rare in Britain, students are at risk in comparison to the general population during their first few weeks of university life. The medical practitioner administering the inoculation is requested to stamp, sign and date this form (see below). Thank you.

***Meningitis vaccination administered:***

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**TO BE COMPLETED BY THE LICENSED MEDICAL PRACTITIONER:****STUDENT DETAILS**

HEIGHT		WEIGHT		BLOOD PRESSURE	
IMMUNIZATION RECORD: Has the student been immunized against the following? Please give approximate date. We strongly recommend that all students be up to date with all relevant immunizations prior to arrival.					
TETANUS TOXOID				POLIOMYELITIS	
BCG or HEAF Test (for TB)				RUBELLA (German Measles)	
OTHERS: e.g. Hepatitis B, measles, mumps, Rubella, etc.					
FOR WOMEN ONLY ( IF APPLICABLE) DATE OF LAST CERVICAL SMEAR					
NOTE: ON ARRIVAL IN THE UK THE STUDENT MAY BE ASKED FOR PROOF OF RECENT BCG(TB) SCREENING/VACCINATION					

IS THE STUDENT CURRENTLY USING ANY KIND OF MEDICALLY PRESCRIBED MEDICATION?	YES		NO	
IF YES, INDICATE NAME OF MEDICATION AND MEDICAL CONDITION.				
PLEASE SPECIFY DOSAGE AND FREQUENCY				
ENSURE THAT THE STUDENT HAS AN ADEQUATE SUPPLY OF ALL ESSENTIAL MEDICATION WHEN THEY JOIN THE UNIVERSITY AND COPIES OF ALL RELEVANT PRESCRIPTIONS.				

**STUDENT'S MEDICAL HISTORY: Has the student ever had, or been treated for the following? (All "YES" answers will require further explanation).**

NO	QUESTION	YES	NO
1	Heart disease, high blood pressure, varicose veins or disease of the circulatory system		
2	Diabetes, goitre or any disease of the glands		
3	Epilepsy, fainting attacks, or other diseases of the brain or nervous system		
4	Fistula, fissure, haemorrhoids or other disease of the rectum		
5	Cancer or tumour, syphilis or tuberculosis		
6	Asthma, pleurisy, or other disease of the respiratory tract		
7	Migraine/headaches		
8	Glandular fever		
9	Any viral illness		
10	Hepatitis		
11	Malaria		
12	Neck or back strain or injury or hernia		



**PHYSICIAN'S STATEMENT:  
(THIS MUST BE COMPLETED FOR THE FORM TO BE VALID)**

HOW LONG HAVE YOU KNOWN THE CANDIDATE?	
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IN WHAT CAPACITY?	
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Question: Given the demands of a university environment, and the location in London, is there any further information that would help the University support the student for the duration of their course?

Answer:

Question: Are you aware of the student having any history of learning difficulties. If so, please describe.

Answer:

I have examined the above named individual and believe this report to be a true and accurate.

PHYSICIAN'S NAME			
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PHYSICIAN'S SIGNATURE		DATE	
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ADDRESS			
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TELEPHONE		FAX	
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**THIS FORM SHOULD BE SUBMITTED WITH THE STUDENTS CONFIRMATION AGREEMENT FORM, OR RETURNED IN THE ENVELOPE MARKED 'CONFIDENTIAL', DIRECTLY TO THE UNIVERSITY CO-ORDINATOR FOR HEALTH AND COUNSELLING**

IF YOU WISH TO DISCUSS THIS FORM OR ANY RELATED ISSUES PLEASE CONTACT THE UNIVERSITY CO-ORDINATOR FOR HEALTH AND COUNSELLING ON THE NUMBERS LISTED BELOW.

TELEPHONE: +44 208 332 8208      FAX: +44 208 332 3050