Occupational Health Service

*Nuffield Centre*

St Michael's Road

*Portsmouth*

PO1 2ED

 Tel 023 9284 3187



**Medical Clearance Health Questionnaire for PGCE / Cert Ed Applicants**

Teachers and those training to become teachers need a high standard of physical and mental health to enter or remain in the teaching profession. You are required to complete this health questionnaire as part of your application your Initial Teacher Training Course. The Occupational Health Nurse/Physician will screen health questionnaires and conduct follow up telephone calls, emails, arrange medicals or with your consent obtain medical reports as appropriate from e.g. your GP / Hospital Specialist. You will receive a letter of notice to inform you of when we are writing to obtain a medical report if deemed necessary.

The Occupational Health Nurse/Physician will advise the University regarding your fitness to teach. No details of any medical conditions will be forwarded to the University without your specific consent. It is very rare for a student to be declared unfit to teach. False information or failure to disclose any significant information could affect your place on the course. You should complete all sections of the form and return by the requested date.

Placements are occasionally outside Portsmouth and may involve some travel. Full time attendance is compulsory. Please declare all medical conditions, including brief details, and any special arrangements you may need so these can be considered before your placements are set. If there is any change in a significant condition after you have completed the form or during your training you should promptly inform Occupational Health.

Delays with completing this form may result in problems for registration

***You are obliged to make the University's Occupational Health Service aware of any changes to your health between completing this health questionnaire and starting your course so that we can consider any necessary adjustments for you.    On starting your course, you should report any health issues to your Tutor who can refer you to the Occupational Health Service for assessment.***

|  |
| --- |
| To be completed by the Candidate |
| Family name | First name(s): |
| Previous name(s): | Title (Mr/Mrs/Ms/Miss): |
| Student number: | Date of Birth: |
| Programme Title: | Course Code: |
| Main address  | Contact telephone numbers: |
| Please provide full address include Country: | Daytime telephone number (where you can be contacted) |
| Dates at this address:  | Evening telephone number:  |
| **Mobile telephone:**  |
| **Email address** |
| Please provide your email address:  |
| **Alternative address –** to be used on dates specified if not available at above address | **Dates at this address** – please state from when to what date you will be at this alternative address |
|  |  |

## Please answer all of the following questions. If you answer yes to any questions, please give further details continuing on a separate sheet of paper if necessary

|  |  |  |  |
| --- | --- | --- | --- |
|  | **Yes** | **No** | **Details and dates****If ‘Yes’ please specify which condition or problem and any treatment received** |
| 1. Have you had any illness, medical problem or disability that may currently affect your ability to work safely as a teacher?
 |  |  |  |
| 1. Have you ever had any illness or health

related problem that may have been made worse by work? |  |  |  |
| 1. Have you ever been medically retired from

any job or studies due to illness? |  |  |  |
| 1. Do you have any hearing problems?
 |  |  |  |
| 1. Do you have any problem with speech or communication? Including use of the telephone?
 |  |  |  |
| 1. Do you have any visual problems?
 |  |  |  |
| 1. Have you ever had a back problem?
 |  |  |  |
| 1. Do you have any difficulties standing, bending, lifting or with any other movements?
 |  |  |  |
| 1. Have you ever had any problems with your

joints including pain, swelling or stiffness? |  |  |  |
| 1. Have you ever suffered from any mental illness, psychological or psychiatric problem, including depression, anxiety, bi-polar, nervous debility, nervous breakdown, schizophrenia or eating disorder?
 |  |  |  |
| 1. Have you ever received any treatment for a drug or alcohol problem?
 |  |  |  |
| 1. Have you ever had any skin problems?
 |  |  |  |
| 1. Have you ever had any blood pressure or

heart problems? |  |  |  |
| 1. In the last 12 months, have you had a cough for more than 3 weeks, coughed up blood or had any unexplained weight loss or fever?
 |  |  |  |
| 1. Have you ever suffered from asthma,

bronchitis or chest problems? |  |  |  |
| 1. Have you ever had hepatitis or jaundice?
 |  |  |  |
| 1. Have you ever had fits, blackouts or

epilepsy?  |  |  |  |
| 1. Do you suffer from migraines or recurrent

headaches? |  |  |  |
| 1. Do you have any other medical

conditions? |  |  |  |
| 1. Are you on any medication at present, including medicine, pills, injections or

inhalers? |  |  |  |
| 1. Do you feel well at present?
 |  |  |  |
| 1. Are you allergic to anything? If so what?

Do you carry an Adrenaline Auto-Injector i.e. epipen? |  |  |  |
| 1. Have you ever been treated in hospital? If

yes please give reason(s) and date(s). |  |  |  |
| 1. Are you waiting for any treatment,

operation or investigation? |  |  |  |
| **Please tells us:** |
| What is your height? | What is your weight? |
| Did you declare any special needs/learning difficulties or support on your application form?  | Are there any special provisions that could be made to assist or enable you to fulfil your training? |
| Have you seen a doctor in the last 2 years for any health problems? |   YES / NO |
| If yes, please give reason(s) and approximate date(s), with the time off work or studies, to the best of your recollection. |
| **Date** | **Nature of Condition** | **Time off needed** |
|  |  |  |
|  |  |  |
|  |  |  |

May we have your consent to approach your doctor and, if necessary, your hospital specialist for further information?

YES / NO

Signed: Date:

**Declaration**

I declare that all of the statements and information I have made on this questionnaire are true to the best of my knowledge. I understand that giving false information or failing to disclose any significant information could result in the offer of a teacher training place being withdrawn.

Signed: Date:

**PLEASE COMPLETE & SIGN HEALTH QUESTIONNAIRE & CONSENT FORM RETURN ALL 5 PAGES AS ATTACHMENTS VIA EMAIL TO** **OCCUPATIONALHEALTH@PORT.AC.UK**

**PLEASE DO NOT SHARE IT VIA GOOGLE DRIVE**

 University of Portsmouth

Occupational Health Service

## Form of Consent for GP / Specialist Medical report

**APPLICANT DETAILS**

Name: …………………………………. Telephone No: ………………………………….

Address: ………………………………. Date of Birth: ……………………………………

………………………………………….

……………………………………….....

**YOUR AUTHORISATION**

I hereby consent to a medical report being supplied in confidence to the Occupational Health Nurse/Physician at the University of Portsmouth. I understand that the clinical details within the medical report received will not be disclosed to the University, but advice based on them might be given to the University.

I am aware of and understand my rights under the Access to Medical Records Act 1988 and have read the associated summary of them. This consent will remain valid for 6 months.

I do / do not wish to have access to the medical report before it is supplied.

 My family doctor is: My Specialist is:

|  |  |
| --- | --- |
| Name:Address:Postcode:Telephone Number: | Name:Address:Postcode:Telephone Number: |

Signed: …………………………………………………………………………………………………

Dated: …………………………………………………………………………………………………..