UFP UNIVERSITY FOUNDATION PROGRAMME EST. 1989

MEDICAL QUESTIONNAIRE

NAME: _____

We are asking for this information so that we can ensure that we provide a safe environment for you in the College, so we are aware of any conditions that may affect your studies, and in case you are involved in a medical emergency. Your information will be not be shared with anyone outside the College except any healthcare professionals from whom you are receiving care.

Please note that if relevant information is <u>not</u> provided on this form, it is assumed that you accept <u>full</u> responsibility for any risks incurred.

DO YOU SUFFER FROM ANY OF THE FOLLOWING?

	Please circle		If you circle "YES", please give further details, including any medication prescribed
Dyslexia / dyspraxia / learning difficulties	NO	YES	
Asthma / bronchitis / chest or breathing difficulties	NO	YES	
Heart condition / high or low blood pressure	NO	YES	
Epilepsy / fits / fainting / blackouts	NO	YES	
Severe headaches / migraines	NO	YES	
Diabetes / thyroid / gland problems	NO	YES	
Allergies to any known drugs	NO	YES	
Other allergies, e.g. to materials, food, hay fever	NO	YES	
Back / joint problems	NO	YES	
Anxiety / depression / other psychiatric disorder	NO	YES	
ANY OTHER illness or disability not listed above	NO	YES	

MEDICAL TREATMENT AND ADVICE

Are you receiving medical or surgical treatment of any kind?	NO	YES	
Have you been given specific medical advice to follow in emergencies?	NO	YES	
Are you taking any medication you have not already mentioned above?	NO	YES	

DECLARATION

I declare that, to the best of my knowledge, the information I have provide is correct and complete.

SIGNATURE: _____ DATE: _____