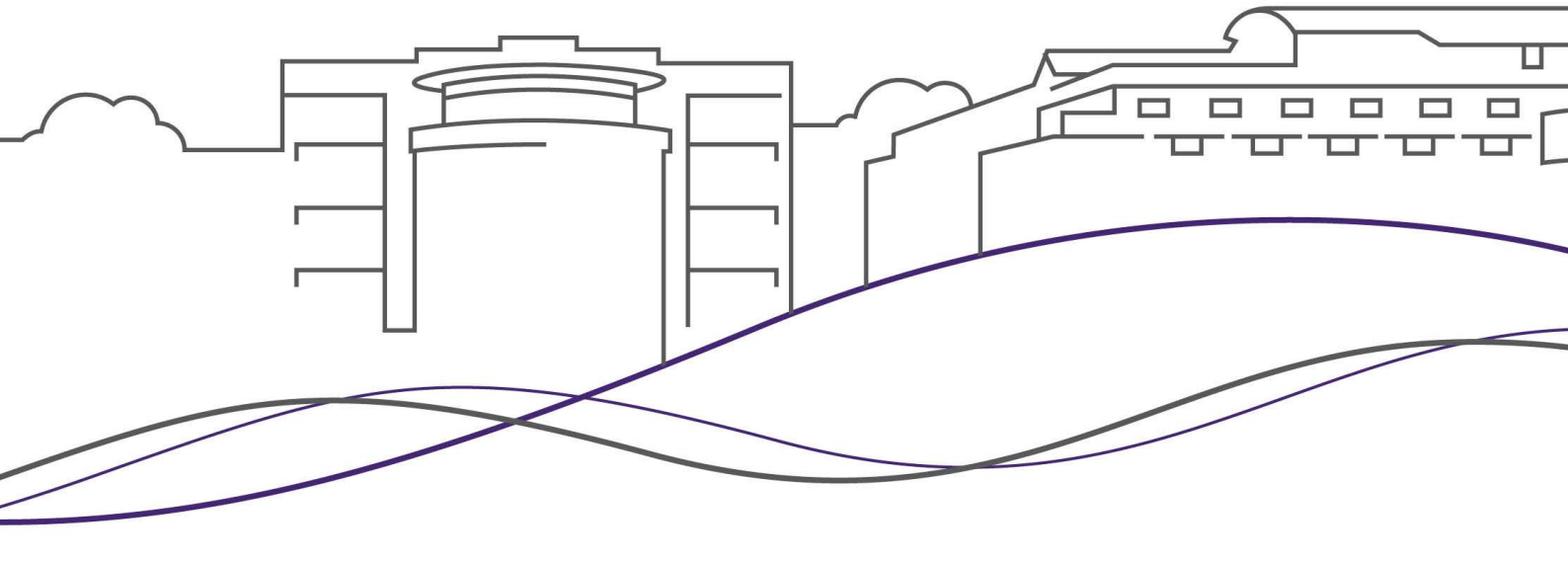
Academic Policy and Procedures

UCSD UNIVERSITY CENTRE SOUTH DEVON | South Devon College | UCSD Health Professions and Nursing — Enhancing Healthcare, Changing Lives

Higher Education

Pre Course Occupational Health Screening Process



Document Control

Document Approved by: HEAB	Date of Approval: 11 Nov 2022
Review by: Health Professions and Nursing	Review Date: Nov 2023
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Version: 4.0	Author: M Woodger

REVISION HISTORY

Ver	Date	Author	Description
1.0	12 Nov 19	J Hall	Conception
2.0	17 Nov 20	M Woodger	Updated to reflect department name
3.0	11 Nov 21	M Woodger	Approved – full review due Feb 22
4.0	09 Oct 22	L Parkin	Updated – full review

APPROVAL

Ver	Committee	Date Approved	Comments
1.0	HEAB	12 Nov 19	Approved
2.0	HEAB	17 Nov 20	Approved
3.0	HEAB	11 Nov 21	Approved
4.0	HEAB	11 Nov 22	Approved

Pre Course Occupational Health Screening Process

Now that you have been made a conditional / unconditional offer of a place to study at the University Centre South Devon (UCSD) we need to be aware of any disabilities or health conditions which are outlined under the Equality Act 2010, which could be relevant to your proposed course of training and future employment. Such information will be carefully considered in advising on your medical suitability for your proposed course. Where considered appropriate we can then advise your programme team of the need to consider any reasonable adjustments or additional support needs both in your own and future patients interests.

The Health Professions and Nursing team at UCSD is committed to providing equality of opportunity for all students and where possible all reasonable support will be provided to enable you to complete the course. However, for those undertaking Healthcare Studies, we need to ensure that you will be able to fulfil the competency standards of the course and of the relevant regulatory body (e.g. NMC/HCPC etc) and following graduation be medically suitable to work within their chosen field.

In the rare case that it is decided that you are medically unsuitable for the course, the team at UCSD will provide you with advice and will make every endeavour to offer you a place on an alternative course.

You have a duty to provide all relevant, truthful and accurate information to UCSD's Occupational Health screening and no information should be withheld. Any failure to do so may result in the offer of a place being withdrawn or reconsideration of your fitness to continue with the course.

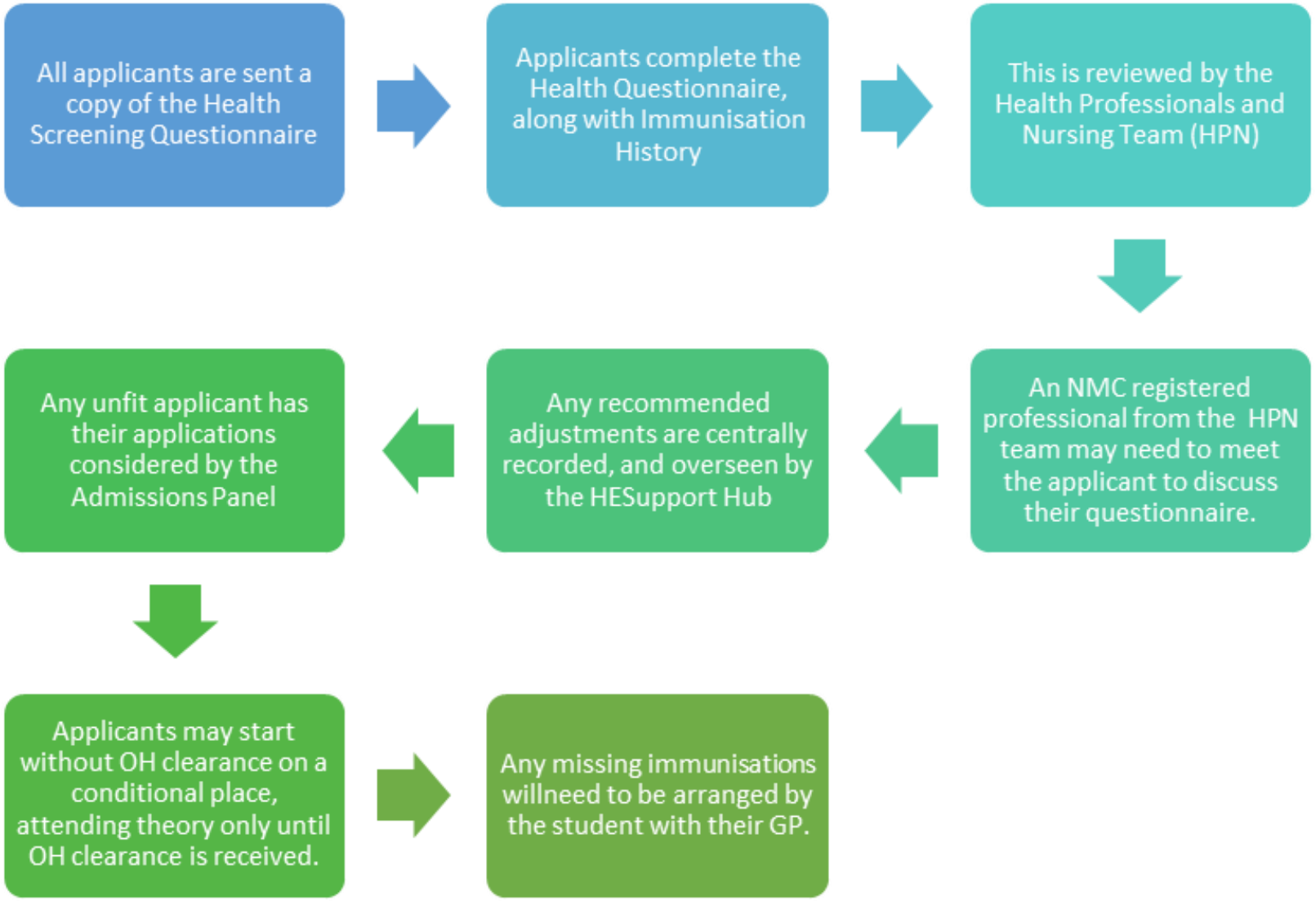
You can be assured that the information will remain confidential, and the programme team will only be informed of the functional effects of any health concerns / disability if this is relevant to your educational needs or pupil safety and of the need to consider reasonable adjustments and/ or additional support.

Please start by completing **Section 1**, which covers personal details etc. In **Section 2,** you are asked to provide information regarding your medical history and current medical condition / functional capacity etc. Please ensure that all relevant details are included, as this will help to avoid the delays involved with approaching you for further information. Please also ensure you complete your vaccination history to support us advising you which vaccinations are necessary to enter your chosen profession. The completed document should then be placed and sealed in the envelope addressed to the UCSD Occupational Health Screening and returned as advised.

Having given careful consideration to your completed form, you may be contacted for further information / to arrange an appointment.

UCSD: Centre for Health & Care Professions

Pre Course Occupational Health Screening Process



SECTION 1: Personal Details

UCSD Student Number								
Family Name:							Forename:	
Title:							Date of Birth:	
Nationality:							Sex: M / F	

University Term Time Address (if known)	Vacation / Home Address
(1)	
Postcode:	Postcode:
Tel No:	Tel No:
Mobile:	Mobile:
Email:	Email:

GP's Name and Address
Tel No:

Course Details:

What is your proposed course	
Date of proposed entry	
Length of course	

Work / Employment History: (if applicable)

Nature of Work	Employer	Start Date	Finish Date

Have you ever had to finish or leave work on health grounds? (Please ✓ as applicable)	Yes	No

If **yes**, please supply details including dates.

Have you ever previously registered at a higher education college/ University for a course of study? (Please ✓ as applicable)	Yes	No

If **yes**, please supply details including dates.

Name of College / University	Start Date	Leaving Date

If you failed to complete the course, please provide details:

SECTION 2

Your Health and Functional Capabilities:

			Yes	No
1	**Do you have problems with any of the following:-**			
	a.	**Mobility?** e.g., walking, using stairs, balance:		
	b.	**Agility?** e.g., bending, reaching up, kneeling down:		
	c.	**Dexterity?** e.g., getting dressed, writing, using tools:		
	d.	**Physical Exertion?** e.g., lifting, carrying, running:		
	e.	**Communication?** e.g., speech, hearing:		
	f.	**Vision?** e.g., visual impairment, colour blindness, tunnel vision:		
If **YES** to any of the above, please give full details (e.g., extent of impairment, how you manage, support needs):				

2.	**Have you ever required special arrangements during your studies / work to accommodate a disability or health concern? (e.g. special equipment, extra time in exams, part-time working)?**	Yes	No
If **YES** please give details: and an indication of date and duration etc			

3	**Do you have, or have you had, any of the following?**		Yes	No
	a.	**Chronic Skin Condition?** e.g., eczema, psoriasis.		
	b.	**Neurological Disorder?** e.g., epilepsy, multiple sclerosis.		
	c.	**Allergies?** e.g., latex, medicines, foods.		
	d.	**Endocrine Disease?** e.g., diabetes.		
	e	**Hep B/ Hep C/ HIV?**		
If **YES** to any of the above please give details including an indication of date and duration etc (e.g. when condition developed, severity, effects and treatment / medication):				

4	Have you ever been affected by:		Yes	No
	a.	**Sudden Loss of Consciousness?** e.g., fit or seizure:		
	b.	**Chronic Fatigue Syndrome?**(or similar condition):		
	c.	**Mental Health Issues?** e.g., anxiety, depression, phobias, OCD, nervous breakdown, personality disorder, over-dose or self-harm, drug or alcohol dependency:		
	d.	**An Eating Disorder?** e.g., bulimia, anorexia nervosa, compulsive eating:		
	e.	**An illness requiring more than two weeks' absence from school or work?**		

If **YES** to any of the above please give details including an indication of date and duration etc (e.g. when condition developed, severity, effects and treatment / medication):

5	Have you ever received treatment from a psychiatrist, psychotherapist or counsellor?	Yes	No

If **YES** to any of the above please give details including an indication of date and duration etc (e.g. when condition developed, severity, effects and treatment / medication):

		Yes	No
6	**Are you currently taking any medication or treatment?**		

If **YES** please give details: including current dose

		Yes	No
7	**Do you have any disability or health condition not already mentioned for which you think you may require support during your employment/ education or training?**		

If **YES** to any of the above please give details:

Note: Please ensure you have answered ALL questions and provided appropriate details. This will help us to make an assessment as quickly as possible and avoid unfortunate delays.

Declaration:

I certify that my answers to the questions are complete, accurate 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 reconsideration of my suitability to continue with my course.

The information supplied by you on this questionnaire will be used to assess your medical suitability to commence your course.

I give my consent for my General Practitioner/Doctor to provide the medical staff at the University Occupational Health Service with any medical information relevant to my application.

Name:	Signature:	Date:

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Data Protection Information

If you join UCSD this questionnaire will form the basis of your Occupational Health record. If you do not join, your questionnaire will be destroyed.

- Records are held in confidence.
- No identifiable medical or other information you provide in confidence and contained in your Occupational Health record will be released by the Occupational Health Service to anyone else without your consent being obtained.
- You may obtain access to your Occupational Health record by contacting the HE Faculty Office.
- The University Centre South Devon will not share your information with any third party.
- **Please return your completed Pre – Acceptance Health Screening Questionnaire:**
- **As Advised By The Programme Team**

VACCINATIONS & DISEASES

Please give details of your vaccinations or known illness against the following diseases. These details may be available from your general practitioner's/Doctor's medical records. If your General practitioner/Doctor is not in full possession of your vaccination history please contact your local Child Health Records Department, which is based at your local Health Authority.

BCG (Tuberculosis):		
	Yes	**No**
Have you had Tuberculosis:		
Is there a family history of Tuberculosis?		
Have you lived or worked abroad for a period greater than 3 months?		
If **YES** please give details of: Date:		
Country:		
	Yes	**No**
Have you been vaccinated against Tuberculosis?		
If **YES** please give details of:		
Date of Tuberculosis vaccination (BCG):		
	Yes	**No**
Do you have a visible scar (usually located on the upper arm)?		
Have you had a recent chest x-ray?		
If **YES** please supply details of dates and location:		

MMR (Measles, Mumps and Rubella) / Varicella (Chicken Pox) Please specify:							
I have had the following disease(s):	**Yes**	**No**	**Don't Know**	**I have received the following vaccinations:**	**Yes**	**No**	**Date Received:**
Measles:				Measles:			
Mumps:				Mumps:			
Rubella:				Rubella:			
				MMR:			
Chicken Pox:				Varicella:			

Hepatitis B:		
	Yes	**No**
Have you previously worked with human tissue, blood or bodily fluids?		
Have you ever been offered Hepatitis B vaccinations?		
If **YES** please provide the following dates and details:		

Date of 1st Dose	**Date of 2nd Dose**	**Date of 3rd Dose**	**Date of blood test**	**Result of blood test lμ/l**	**Date of Booster**

Other:

Vaccinations:	**Dates Of Vaccinations:**				
Pertussis (Whooping Cough)	1st	2nd	3rd		
Polio	1st	2nd	3rd	4th	Booster
Tetanus	1st	2nd	3rd	4th	Booster
Diphtheria	1st	2nd	3rd	4th	Booster
Meningitis C					
Other (specify)					

Please ensure that you have answered ALL of the questions. Your assessment cannot be completed until you do.

Practice Stamp