**IMPORTANT IMMUNITY AND VACCINATION REQUIREMENTS BEFORE STARTING YOUR COURSE**

**INCOMPLETE INFORMATION WILL AFFECT YOUR STARTING DATE**

This document contains important information regarding immunisations that are required by St George’s, University of London and FHSCE, Kingston University. As a healthcare student you will have regular contact with vulnerable patients during your training. In the event of these patients contracting diseases such as Measles, Chickenpox or Tuberculosis, the mortality and morbidity is unacceptably high compared to normal healthy people. Rubella can cause significant abnormalities in an unborn child if a pregnant woman becomes infected. Additionally hospitals you will be attached to during your training have strict policies regarding immunity requirements before you are allowed to have contact with patients.

**The following vaccinations are MANDATORY before starting your training.**

1. **MMR (MEASLES, MUMPS AND RUBELLA)**

You must submit the following as a proof of Measles Mumps and Rubella immunity:

* **Documented evidence** (eg GP vaccine printout) of having two doses of measles, mumps, rubella vaccines (MMR)

**OR**

* **Blood test report** showing immunity to measles, mumps & rubella.

If you do not have either of these, **YOU MUST** arrange immediately via your GP to receive **two doses of MMR vaccine**, administered a month apart

1. **HEPATITIS B VACCINE**

You will be exposed to blood and body fluids during your training and you **must be vaccinated against Hepatitis B virus** and have evidence of immunity by having a post vaccine blood test. **If you have not had the vaccination, please commence the course immediately** with your GP practice. The first three doses are given at monthly intervals followed by a blood test 8 weeks later to check the response, with a final injection one year after the first injection.

1. **MENINGOCOCCAL MENINGITIS**

Meningococcal disease is a severe bacterial infection of the bloodstream or meninges. Anyone can get meningococcal disease, but it is commonly contracted by first year university students. The Department of Health recommends that any unvaccinated individual attending university, irrespective of age, should be immunised before they enrol. **PLEASE IMMEDIATELY CONTACT YOUR GENERAL PRACTITIONER** to arrange a single dose of **Meningitis C containing conjugate vaccine.**

1. **OTHER VACCINES**

Please contact your General Practitioner and make sure that you are up-to-date with vaccination against Diphtheria, Purtussis (Whooping Cough), Poliomyelitis and Tetanus.

1. **SCREENING FOR CHICKENPOX, TUBERCULOSIS, HIV, HEPATITIS B AND C**

Screening for the above will be carried out by the Occupational Health Department on starting and students must attend with either their photo driving licence or passport.

**CONFIDENTIAL HEALTH QUESTIONNAIRE**

**Complete after you have received an offer of a place in the course. The contents of this form are held in strict confidence by the Occupational Health Department.**

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| **INSTRUCTIONS:** * Please complete the Health Questionnaire **fully** and in BLACK INK. Leaving questions unanswered will delay the health clearance and your start date for the course.
* You are **required to take the additional questionnaire (Report from General Practitioner) with the signed consent form to your general practitioner** for completion. You will have to meet any charges levied by the General Practitioner.
* You should return your questionnaire, **together** with the General Practitioner Questionnaire, in the envelope provided **as soon as possible to ensure that you are health cleared by the start date. Your health questionnaire will NOT be screened unless your complete GP report is present.**
* Please supply any specialist reports that you many have relating to any physical or mental health conditions and all up to date immunisation records, bringing the latest one to your OH appointment.
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| --- | --- |
| **Course Title:** |  |
|  |  |  |  |
| **Title (delete):**  | Dr/Mr/Mrs/Miss/Ms/other | **First Name:** |  |
| **Surname:** |  | **Maiden Name****(if applicable):** |  |
| **Date of Birth:** |  | **Gender (delete):** | Male/Female |
| **Home address:** |  | **Home Telephone:****Mobile Telephone:****Email address:** |  |
|  |  |  |  |
| **General Practitioner’s details below:** |
| **Name:** |  | **Telephone No:** |  |
| **Address:** |  |  |  |

The University is fully committed to supporting students with disabilities. A careful assessment will be carried out to identify the areas in the course where a health condition may impact your studies and support will be arranged. If your health will impact on achieving the competencies required for the course, we will look at reasonable adjustment with the involvement of senior teaching staff. You will only be rejected on medical grounds if it is shown that you will not meet the core competencies of the course despite the adjustments and the decision will be made after consulting senior staff of the University.

**IF YOU KNOWINGLY MAKE A FALSE STATEMENT OR CONCEAL ANY INFORMATION REGARDING YOUR MEDICAL HISTORY, YOU WILL BE LIABLE TO HAVE YOUR TRAINING TERMINATED.**

**PLEASE ANSWER THE FOLLOWING QUESTIONS BY TICKING THE APPROPRIATE YES/NO BOX. IF THE ANSWER IS YES PLEASE GIVE DETAILS IN THE SPACE PROVIDED. YOU SHOULD CONTINUE ON THE NEXT PAGE IF NECESSARY.**

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| **All questions MUST be answered** |
|  | **Health Question**  | **Yes**  | **No**  | **If Yes:*** give details in the box in this column and the box next page,
 |
| 1 |  Are you at present, receiving any treatment or regular medication supervised by your doctor? If yes, give details: |  |  |  |
| 2 | Have you lost time from Work/School due to illness in the last 2 years?  |  |  | *Please state how many days or weeks and on how many occasions and the reasons.*  |
| 3 | Have you ever received medication, seen a doctor, a therapist, counsellor or admitted or treated for the following: |  |  |  |
| 1. Mental Health problems *(including anxiety, phobias, depression, bi-polar disorders, psychosis, schizophrenia, eating disorders, obsessive compulsive disorder, autism or related disorders or personality disorder?*
 |  |  |  |
| 1. Use or have you used illegal / recreational drugs or do you have or have you had any alcohol/substance misuse problems?

What is your weekly alcohol consumption? |  |  |  |
| 1. Musculoskeletal problems (such as arthritis, pains in arms or legs, neck or back pain)?
 |  |  |  |
| 1. Epilepsy or recurrent faints?
 |  |  |  |
| 1. A neurological condition or injury that affected your memory or concentration?
 |  |  |  |
| 1. Diabetes?
 |  |  |  |
| 1. Chronic fatigue
 |  |  |  |
| 1. Cough which lasted for more than 3 weeks, weight loss or have been investigated for Tuberculosis?
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| 1. positive to or carrier of Hepatitis B, C, HIV or have a infectious disease such as typhoid
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| 1. Did you have cancer or Immuno-suppression due to an illness or taken high dose steroid or chemotherapy within the past one year?
 |  |  |  |
| 1. Allergies including sensitivity to medicines, vaccines, detergents, Latex or other gloves
 |  |  |  |
| 4 | Have you had or anticipate difficulty doing overnight or 12 hours shifts? |  |  |  |
| 5 | Hearing impairment for which you attended a hospital clinic for assessment or wear a hearing aid? |  |  |  |
| 6 | Visual impairment (including colour vision) that could not be corrected by wearing spectacles? |  |  |  |
| 7 | Do you have dyslexia or dyspraxia?If so, please enclose relevant reports. |  |  |  |
| 8 | Any other health conditions not declared above requiring hospital treatment, investigation or may impact on your studies? If yes please give details |  |  |  |
| 9 | Did you receive any support such as extra time, equipment and special adjustments at school/ university/work with learning, examinations, assessments and work place attachments? Please give details  |  |  |  |
| 10 | **Weight (kg)** |  | **Height (cm)** |  |  |

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| Please give much detail as possible to the questions you have responded yes in the previous page. This will minimize delay in processing your health clearance. Give details of the main symptoms, diagnosis, details of the investigations, treatment, current symptoms and treatment.**Please attach relevant medical and assessment reports.** |

**YOU MAY BE REQUIRED TO UNDERGO A HEALTH EXAMINATION/ OCCUPATIONAL MEDICAL EXAMINATION WHICH MUST TAKE PLACE BEFORE YOUR COURSE COMMENCES AND BEFORE BEING FINALLY HEALTH CLEARED.**

***Please note that this OH form should be returned in a sealed envelope.  Other documents must not be included in this envelope.  Failure to do so may delay processing time and clearance checks for your conditional offer. The envelope containing your OH and GP forms should be labelled with your full name (block capitals only); date of birth and course name***.

**IMMUNISATION RECORD**

There are strict immunity screening and vaccination requirements marked by \* for entry to healthcare science courses.You must give information and attach copy of reports and vaccine records. **You will not be health cleared without the essential immunity information.**

Read the document **‘Important immunity and vaccination requirements before starting your course’**

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| Immunisation and vaccination details – to be completed in detail. If you have not had a specific vaccine – answer NO to the questions – **do not answer not applicable (N/A) in the spaces please**. Please send copies of your vaccine history/results with this completed form. *Midwifery students will need to attend for an appointment for HIV, HepB and HepC blood testing BEFORE starting their course*.  |
| Have you entered the UK in the last 5 years? If yes, which country Yes [ ]  No [ ]  | Are you expected to be doing Exposure Prone Procedures (medical, physician assistant, midwifery and paramedic students only)? Yes [ ]  No [ ]  |
| BCG vaccine\* Yes [ ]  No [ ] Date \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | Do you have a BCG scar? (normally found on upper arm) Yes [ ]  No [ ] Scar Size\_\_\_\_\_\_\_\_mm | Have you had a Heaf test or Mantoux test for TB?Yes [ ]  /No [ ]  | What were the results of the Heaf/Mantoux?Grade/Size\_\_\_\_\_\_\_\_\_\_\_\_\_\_Date\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| Hepatitis B primary course\* | Yes [ ]  No [ ]  | Dates of injections |
| Hepatitis B Booster(s) | Yes [ ]  No [ ]  | Dates of injections |
| Hepatitis B levels | Yes [ ]  No [ ]  | Date of Test and results (miu/ml) |
| Hepatitis Surface Antigen B (IVS) | Yes [ ]  No [ ]  | Date of Test and results |
| Hepatitis C (IVS) | Yes [ ]  No [ ]  | Date of Test and results |
| HIV (optional test) (IVS) | Yes [ ]  No [ ]  | Date of Test and results |
| Have you had chicken pox / shingles | Yes [ ]  No [ ] Date\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | Have you had a meningitis vaccine? Yes [ ]  No [ ] Date\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| Have you had the MMR\* | Yes [ ]  No [ ]  | Dates of injections 1. 2.  |
| Immunity (blood) test for: | Date of blood test | Result |
| Measles |  |  |
| Mumps |  |  |
| Rubella |  |  |
| Chicken Pox/Varicella/VZV |  |  |

There are **mandatory requirements for immunity screening and vaccination**. Places are offered on the understanding that the applicant will comply with local requirements regarding immunisations. Please state whether you agree to this: **YES /NO (delete)**

 **DECLARATION:**

**The answers in this questionnaire are true and complete to the best of my knowledge.**

**Signed: ........................................................................ Date: ....................................**

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| **OCCUPATIONAL HEALTH DEPARTMENT**St George’s University Hospitals Foundation NHS Trust, Blackshaw Road, London, SW17 0QTTel: 020 8725 1661/2 – Fax: 020 8725 3087 |

Dear Colleague

This student has applied to a healthcare sciences degree at St George’s University of London or Kingston University and has been offered a place. As a routine screening prior to entry it is necessary for the applicant to complete a health questionnaire and for you to check the applicant’s notes and complete the attached form. The student **must** supply you with their completed health questionnaire, so that you have the opportunity to confirm that any medical information or clinical history is correct and that the student has made no omissions or misquoted a condition. Students are aware that they must have declared to us, **ANY** mental and physical health episodes with the time periods associated with the episode.

As you will understand it is important for us to make sure that anyone joining a clinical profession will be able to withstand the rigors of such a demanding career**.** You must **not** complete this form if:

* You are related to the patient.
* If you do not hold the applicants notes or the notes that you have do not go back more 2 years.
* If you are the Practice Nurse or Nurse Practitioner or administrative staff.

If you require additional clarification as to the standards that we assess against, please feel free to visit the Higher Educational Occupational Physicians/Practitioners website <http://www.heops.org.uk/HEOPS_guidance_and_fitness_standards.php>

It is the students responsibility to meet any costs relating the production of this report.

Yours sincerely

**Dr Sam Thayalan MRCP MFOM**

**Consultant Occupational Physician**

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| **OCCUPATIONAL HEALTH DEPARTMENT**St George’s University Hospitals Foundation NHS Trust , Blackshaw Road, London, SW17 0QTTel: 020 8725 1661/2 – Fax 020 8725 3087 |

**REPORT FROM GENERAL PRACTITIONER**

**(N.B. Contents are held in strict confidence by the Occupational Health Department).**

**Candidate's Name:**

**Candidate's Address:**

**Candidate's Date of Birth:**

**Course:**

**Year for which applied for commencement:**

**Dear Doctor,**

**The above-named has applied for clinical degree and we should wish the following questionnaire to be completed (the costs to be borne by the applicant):**

|  |  |  |
| --- | --- | --- |
|  | **YES** | **NO** |
| Are you (or your practice) the GP of the above named? |  |  |
|  Are you in possession of his/her full medical records? If not, please state from which year your records date:  |  |  |
| Has he/she suffered from any significant (acute or chronic) medical or physical conditions? e.g. Back conditions Skin Conditions Epilepsy or other loss of consciousness Diabetes Surgical operations **IF YES, please give details overleaf.** |  |  |
| Has he/she ever suffered from Psychological/Psychiatric conditions? e.g. Mental illness Self-harm Substance abuse Eating disorders **IF YES, please give details overleaf.** |  |  |

**N.B.** The applicant is aware of his/her rights under the Access to Medical Reports Act. This form should be returned to the applicant after completion. If you feel this is inappropriate, please inform the applicant and, with his/her permission, send the form direct.

 **If you have any reports from specialists, we would be very grateful for copies of these reports, to expedite health clearance.**

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| **Any other relevant information:****Continue on separate sheet if necessary** |

**Doctor's Signature: ............................................................... Date: ………………**

**Print Name: .............................................................. GMC No. ……………………..**

**Practice Address:**

|  |
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| Practice Stamp – this **must** be included – please use a rubber stamp rather than a label (needed due to counter fraud). |

**PLEASE NOTE:** a positive answer to any question does not automatically bar the candidate from employment/training, nor are you asked to give your opinion on this candidate's fitness for the course.

Every applicant will be given the opportunity for an independent occupational health screen if appropriate.

Many thanks for your co-operation.

**Dr Sam Thayalan MRCP MFOM**

**Consultant Occupational Physician**

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**ACCESS TO MEDICAL REPORTS ACT 1988**

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| **OCCUPATIONAL HEALTH DEPARTMENT**St George’s Healthcare NHS Trust, Blackshaw Road, London, SW17 0QTTel: 020 8725 1661/2 – Fax 020 8725 3087 |

This Act affords to members of staff the right to check the accuracy of Medical Reports prepared by Doctors before they are submitted to the Occupational Physician.

Before you sign the consent form you should be aware that:

• You may withhold your consent for the application to be made.

• You may request to see the report before it is supplied to the Occupational Physician.

• You may ask the Doctor to amend any part of the report which you consider to be incorrect or misleading.

• If the Doctor declines to alter the report you may attach a written statement giving your views.

• You may withhold permission for the report to be supplied.

N.B. Any request for alteration or the withholding of a report must be in writing.

The Doctor may withhold sections of the report from you if he/she feels that to see them would be harmful to you.

Should you indicate that you wish to see the report, you will be notified on the day that the report is requested. You will then have twenty one days in which to make your own arrangements with the Doctor to see the report before it is dispatched. If you have indicated that you do not wish to see the report, the Doctor may dispatch it without delay.

If you require a copy of the report the Doctor may charge you a fee.

If you withhold consent for the supply of a medical report, the Occupational Physician will be within his/her rights to make a decision on the evidence available to him/her.

Signed:

Print name:

Date:

Date of Birth:

Course applied for: