

Reading School of Pharmacy Student Health Declaration Form

As part of your clearance to commence any patient-facing experience, you are required complete this health declaration form **and** provide a copy of vaccination evidence of protection against MMR (Varicella and BCG if applicable).

Title: Mr / Mrs / Miss / Ms	Date of Birth:
Surname:	Forename:
Term time address: Post code:	Home address:
GP name: GP Address: Post Code: Tel:	Mobile: University email: Personal email:

Please answer ALL questions below. Provide further information as required		YES	NO	FURTHER INFORMATION
1	Have you had a BCG vaccination? (this is not mandatory)			Date: Place:
2	Do you have a visible BCG scar?			Scar site:
3	Have you had or been treated for Tuberculosis (TB)?			If yes:- - when were you treated? - did you complete the treatment?
3	Have you been exposed to TB (e.g. through a family member or close friend)			
4	In the last year, have you...			
	i. Had a cough lasting more than 3 weeks?			
	ii. Coughed up blood?			
	iii Had intermittent fever?			
	iv Had unexplained weight loss?			
	v Had heavy sweating at night?			
5	Are you currently being treated for any other conditions?			If you have answered yes, a member of staff will contact you in confidence to discuss further

Immunity status – including vaccinations		YES	NO	FURTHER INFORMATION
6	Measles, mumps, rubella (MMR)			1 st vaccination date: 2 nd vaccination date: Rubella serology status if known:
7	Varicella (chicken pox) vaccinations If no, Any history of having chicken pox or shingles?			1 st vaccination date: 2 nd vaccination date: If yes: when (approximate age/year)?
8	Hepatitis B (this is not mandatory)			1 st vaccination date: 2 nd vaccination date: 3 rd vaccination date: Booster date:

DECLARATION

Please sign below when you have read, understood and accepted the declaration.

I declare that, to the best of my knowledge, all the information given in this document is true. I understand that if I fail to disclose information, or make a false statement, that this may lead to the termination of my placement visits and that the matter may also be considered as part of the Reading School of Pharmacy Fitness to Practice procedure.

The information you give here and that given by your GP or medical adviser will be used to make a decision about your fitness to commence any patient-facing experience and also to assess whether any further support from the University Occupational Health Service provider (i.e. University of Reading Medical Practice (UoRMP)) will be required. If further support (e.g. blood test, vaccinations) is needed, such information will be shared with UoRMP.

I consent to a medical interview/examination if necessary.

I agree to accept relevant immunisations/investigations that may be necessary in ensuring my fitness to undertake the placements. I understand that this incur a cost that I will be required to pay. I also agree to report to the MPharm Placement Lead and UoRMP should I need to cancel an appointment and that I should provide at least 72 hours' notice.

I consent for information regarding any immunisations/investigations carried out by UoRMP to be sent to the MPharm Placement team.

I agree to report to the placement tutor if I have contact with, or suffer from, any illness/disorder which could present a health hazard to other students, staff or patients.

SIGNED: Print name: DATE:

Staff Use ONLY

		YES	NO	Comment for staff
1	TB history check			GP print out or Childhood vaccination record
2	MMR vaccine check			GP print out or Childhood vaccination record
3	Varicella vaccine check			GP print out or Childhood vaccination record
4	Chicken pox history			verbal confirmation will be sufficient
5	Hep B vaccine check			GP print out or Childhood vaccination record
Staff Name		Staff Signature		Date