STUDENT HEALTH FORM

Use pen not pencil. Please write clearly. You can either tick ☑ or cross ☒. This form is designed to make IPU New Zealand and IPU New Zealand Health Clinic aware of any of your previous medical/surgical history and current medical conditions. For more information or assistance, please email Areg@ipu.ac.nz or contact a student support officer.

IPU NEW ZEALAND TERTIARY INSTITUTE

A. PERSONAL DETAILS

A.1 STUDENT ID

A.2 FAMILY NAME

A.3 FIRST NAME(S)

A.4 GENDER

A.5 DATE OF BIRTH (Day/Month/Year)

A.6 PLACE OF BIRTH (Town/City/Province)

A.7 COUNTRY OF BIRTH

A.8 COUNTRY OF CITIZENSHIP

B. PERSONAL MEDICAL HISTORY

B.1 Are you allergic to any medicine or injections? i.e. Are there any medicines you cannot take? If yes, what happens when you take these medicines and what are their names?

☐ Yes ☐ No

B.2 Do you currently take any prescribed medicines? If yes, please write their names

☐ Yes ☐ No

B.3 Have you taken any prescribed medicines in the past for longer than a month? If yes, please write their names.

☐ Yes ☐ No

B.4 Have you ever been addicted to a drug or taken drugs illegally? If yes, what kind and how much?

☐ Yes ☐ No

B.5 Do you smoke, or take any recreational drugs e.g. marijuana, ecstacy? If yes, what kind and how much?

☐ Yes ☐ No

B.6 Have you ever been admitted to hospital for a medical condition?

☐ Yes ☐ No

B.7 Have you ever had, or been advised to have, a surgical operation?

☐ Yes ☐ No

B.8 Have you seen a counsellor in the last three years to discuss emotional distress or other matters? e.g. self-harm, depression

☐ Yes ☐ No

B.9 Have you ever been refused on medical grounds any of the following?

Entry to another country ☐ Yes ☐ No

Life or Health Insurance ☐ Yes ☐ No

B.10 Are you allergic to any food? If yes, what food?

☐ Yes ☐ No

B.11 If you have answered yes to any of questions B.1-9 Please provide details below

B.12 Do you smoke or have you ever smoked cigarettes?

☐ Yes ☐ No

a. If yes, please specify:

how many per day?

for how many years?

how old were you when you started?

b. If you have stopped smoking:

how old were you when you stopped?

B.13 Do you drink any alcohol?

☐ Yes ☐ No

a. If yes, please specify what type you drink (eg. beer, wine, pre-mix)

b. how many drinks per day?

FEMALE ONLY QUESTIONS

B.14 Do you experience any significant problems with your menstrual cycle? e.g. heavy bleeding, a lot of pain, irregularity

☐ Yes ☐ No

If yes, do you take any medication for this?

☐ Yes ☐ No

B.15 Have you ever had a cervical smear done?

☐ Yes ☐ No

If yes, write the date of last smear (Day/Month/Year)

B.16	Do you have or have you ever had:	Yes	No
a.	Deafness/chronic ear infections?	☐	☐
b.	Blindness/Vision/Sight problems?	☐	☐
c.	Do you wear glasses or contact lenses?	☐	☐
d.	Diagnosed mental illness?	☐	☐
e.	Depression or anxiety?	☐	☐
f.	Sleep or fatigue/tiredness problems?	☐	☐
g.	Nutrition or eating disorders?	☐	☐
h.	Stomach or gastric problems?	☐	☐
i.	Chronic pain syndrome / Pain problems?	☐	☐
j.	Speech problems?	☐	☐
k.	Sensory concerns e.g. loss of sensation, tingling, alteration in taste?	☐	☐
l.	Epilepsy or other fits?	☐	☐
m.	Tuberculosis (TB)?	☐	☐
n.	Hepatitis? (If yes, please specify type)	☐	☐
o.	Genetic or familial disorders?	☐	☐
p.	AIDS/AIDS related conditions?	☐	☐
q.	Any immunodeficiency syndrome?	☐	☐
r.	Gastro-intestinal disorders?	☐	☐
s.	High blood pressure?	☐	☐
t.	High cholesterol?	☐	☐
u.	Arthritis?	☐	☐
v.	Heart or Cardiovascular disease?	☐	☐
w.	Diabetes?	☐	☐
x.	Rheumatic fever?	☐	☐
y.	Asthma or Respiratory / Breathing problems?	☐	☐
z.	Migraine?	☐	☐
a1.	Tonsillitis, or frequent throat infections?	☐	☐
b1.	Skin disorder or disease?	☐	☐
c1.	Any type of cancer?	☐	☐
d1.	Did you have any serious childhood illnesses that have affected your life?	☐	☐
e1.	Any other illness?	☐	☐

B.17 **If you have answered yes to any of the above medical conditions, please provide the question number and details, including details of the condition, when and how it happened, medications currently taken or prescribed for this condition in the past**

B.18	Have you been immunised against:	Yes	No	Not Sure
a.	Tetanus?	☐	☐	☐
b.	Hepatitis B?	☐	☐	☐
c.	Hepatitis A?	☐	☐	☐
d.	Morbilli (English measles)?	☐	☐	☐
e.	Tuberculosis (TB)?	☐	☐	☐
f.	Rubella (German measles)?	☐	☐	☐
g.	Mumps?	☐	☐	☐
h.	Pertussis (Whooping cough)?	☐	☐	☐
i.	Meningococcal B?	☐	☐	☐
j.	What other immunisations did you receive before coming to NZ?	☐	☐	☐

B.19 **Please provide details of any other medical conditions that IPU New Zealand should be aware of.**

C. FAMILY MEDICAL HISTORY

C.1	Have any immediate family members suffered from:	Yes	No	Not Sure
a.	Asthma?	☐	☐	☐
b.	Epilepsy?	☐	☐	☐
c.	Diabetes?	☐	☐	☐
d.	Tuberculosis (TB)?	☐	☐	☐
e.	Migraine?	☐	☐	☐
f.	Mental illness / Anxiety / Depression?	☐	☐	☐

C.2 **Please provide details of your family's medical history that IPU New Zealand should be aware of.**

The above is true and correct and no information has been withheld. I understand that any health information provided that affects my learning will become a part of my database files and that Academic Registry, Deans, Assistant Deans and Student Support have access to this information. I give consent for the IPU New Zealand Health Clinic to deliver treatment based on assessed needs which have been explained, discussed and agreed upon by myself, the Registered Nurse and a Medical Practitioner and other Health Professionals (as appropriate). I permit my health information to be released to and from the IPU New Zealand Health Clinic to Health Agencies / Health Professionals that are responsible for my care and treatment, such as medical laboratories for testing samples, specialists referred to for specified treatments. I understand that IPU New Zealand and IPU New Zealand Health Clinic will not disclose my information to any other agency unless I authorise them to do so. I understand that my health information will be given, used and stored in accordance with the Health Information Privacy Code 1993. I understand that the original form will be kept at the IPU New Zealand Health Clinic and its duplicate in Academic Registry. I understand that under the Health Information Privacy Code 1993, I have the right to request access to, and correction of, any information held by you.
I understand, as a part of health and safety procedures, I need to submit a copy of my vaccination certificate(s) to IPU New Zealand.

SIGNATURE OF APPLICANT

DATE

SIGNATURE OF PARENT OR GUARDIAN
(if student is under 18 years old)

DATE