



POST GRADUATE CERTIFICATE OF EDUCATION (PGCE) STUDENT HEALTH ASSESSMENT

Information to prospective students

Following the offer of a place to study teaching at the University of Cambridge, your answers to this health questionnaire will help to ensure that your teacher training will not place your health at risk and will also help to determine, in terms of fitness to fulfil the requirements of the Department for Education (DfE), and the Education (Health Standards) (England) Regulations (2003), your suitability to work as a teacher. For further information, please see the following [Higher Education Occupational Practitioners guidance about trainee teachers and standards of medical fitness to train](#).

As a potential future teacher you have a *duty* to provide all relevant and accurate information to the University Occupational Health Service where it will be held in confidence.

The Faculty will only be informed of any functional effects of any health problems or disability if this is relevant to your educational needs or pupil safety. The Faculty is committed to ensuring equality of opportunity for students with impairments and health conditions, and will provide all reasonable support to enable students with such conditions to complete the course. Please complete Section 1 and go on to each of the following questions in Section 2 and, in the case of positive answers, provide additional information in the space provided (attaching further details on a separate sheet where necessary). If you require special aids or have special needs please give details of these and indicate whether they have already been discussed during the admissions process. If not, please contact the Faculty Admissions staff and/or the University of Cambridge Disability Resource Centre, tel: +44(0)1223 332301 email: disability@admin.cam.ac.uk

The completed document should then be sent to the University's Occupational Health Service, 16 Mill Lane, Cambridge, CB2 1SB.

If you declare an impairment or health condition which may require adjustments to assist you in your training or affect your work as a teacher then an Occupational Health Adviser will contact you to assist you further.

Should you require further information or have any health related queries, please contact the University of Cambridge Occupational Health Service

email OccHealth@admin.cam.ac.uk or tel: +44(0)1223 336594

Data Protection Information

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

The information that you supply on this questionnaire will be held in confidence by the University Occupational Health Service as part of your occupational health record. For full details of how your personal information is used by the University Occupational Health Service, please see <http://www.oh.admin.cam.ac.uk/general-information/confidentiality-statement>

You may obtain access to your Occupational Health (OH) record at any time by contacting:

Occupational Health
16 Mill Lane
Cambridge
CB2 1SB

Tel: +44 (0) 1223 336594
Fax: +44 (0) 1223 762948
Email: OccHealth@admin.cam.ac.uk

Section 1 – Personal Details

Surname Title: Mr /Mrs / Miss / Ms / Dr / Other

First names Date of Birth

Contact Address

..... Post code

Telephone Numbers Home: Mobile:

E-mail address

GP Name and Address

.....

GP Telephone number

Course applied for Age range to be taught

Subject Specialism
(Secondary only)

Section 2 - Health and Functional Capabilities

<p>1. Do you have problems with any of the following?</p> <p>a. Mobility e.g., walking, using stairs, balance</p> <p>b. Agility e.g., bending, reaching up, kneeling down</p> <p>c. Dexterity e.g., getting dressed, writing, using tools</p> <p>d. Physical exertion e.g., lifting, carrying, running</p> <p>e. Communication e.g., speech, hearing</p> <p>f. Vision e.g., visual impairment, colour blindness, tunnel vision</p> <p>g. Learning e.g., dyslexia, dyspraxia, dyscalculia, impaired concentration</p>	<p>Yes <input type="checkbox"/> No <input type="checkbox"/></p> <p>Yes <input type="checkbox"/> No <input type="checkbox"/></p> <p>Yes <input type="checkbox"/> No <input type="checkbox"/></p> <p>Yes <input type="checkbox"/> No <input type="checkbox"/></p> <p>Yes <input type="checkbox"/> No <input type="checkbox"/></p> <p>Yes <input type="checkbox"/> No <input type="checkbox"/></p> <p>Yes <input type="checkbox"/> No <input type="checkbox"/></p>
-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------	-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------

If yes to any of the above, give details e.g., extent of impairment, how you manage, necessary support needs.

.....

.....

.....

.....

<p>2. Have you ever required special arrangements at school or work to accommodate a disability or health problem? e.g. special equipment, extra time in exams, part-time working</p>	<p>Yes <input type="checkbox"/> No <input type="checkbox"/></p>
---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------	-----------------------------------------------------------------

If yes, give details.....

.....

.....

.....

.....

Where applicable please indicate whether or not you have informed your Admissions Tutor and/or the University of Cambridge Disability Resource Centre (DRC) about any impairment or disability that requires support during your training.

Admissions Tutor Yes No

University of Cambridge DRC Yes No

If you have contacted the University of Cambridge DRC do you consent to OH informing the Faculty of Education of this to ensure that any necessary support needs can be considered prior to you commencing the course? Yes No

If you do not consent to OH contacting the Faculty, and you are seeking support, please contact your Admissions Tutor, the DRC or OH to discuss your needs.

<p>3. Do you have any of the following?</p> <p>a. Chronic skin conditions e.g., eczema, psoriasis</p> <p>b. Neurological disorders e.g., epilepsy, multiple sclerosis</p> <p>c. Allergies e.g., to latex, medicines, foods</p> <p>d. Endocrine disease e.g., diabetes</p>	<p>Yes <input type="checkbox"/> No <input type="checkbox"/></p> <p>Yes <input type="checkbox"/> No <input type="checkbox"/></p> <p>Yes <input type="checkbox"/> No <input type="checkbox"/></p> <p>Yes <input type="checkbox"/> No <input type="checkbox"/></p>
-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------	-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------

If yes to any of the above, give details e.g., when condition developed, severity, its effect on you, treatment.....

.....

.....

.....

.....

<p>4. Have you ever been affected by?</p> <p>a. Sudden loss of consciousness e.g., a fit or seizure</p> <p>b. Chronic fatigue syndrome (or similar condition)</p> <p>c. An illness requiring more than two week's absence from school or work</p> <p>d. Mental health problems e.g., anxiety, depression, phobias, OCD, nervous breakdown, personality disorder, over-dose or self-harm, drug or alcohol dependency</p> <p>e. An eating disorder e.g., bulimia, anorexia nervosa, compulsive eating</p>	<p>Yes <input type="checkbox"/> No <input type="checkbox"/></p> <p>Yes <input type="checkbox"/> No <input type="checkbox"/></p> <p>Yes <input type="checkbox"/> No <input type="checkbox"/></p> <p>Yes <input type="checkbox"/> No <input type="checkbox"/></p> <p>Yes <input type="checkbox"/> No <input type="checkbox"/></p>
--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------	---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------

If yes to any of the above, give details e.g., when condition developed, how long it lasted, its effects on you, treatment

.....

.....

.....

.....

.....

.....

5. Have you ever been assessed or treated by a psychiatrist, psychotherapist or counsellor?	Yes <input type="checkbox"/> No <input type="checkbox"/>
---------------------------------------------------------------------------------------------	----------------------------------------------------------

If yes give details e.g. when, reason, outcome.....

.....

.....

6. Are you currently taking any medication or treatment?	Yes <input type="checkbox"/> No <input type="checkbox"/>
----------------------------------------------------------	----------------------------------------------------------

If yes give details.....

.....

.....

7. Do you have any disability or health condition not already mentioned for which you think you may require support during your training?	Yes <input type="checkbox"/> No <input type="checkbox"/>
-------------------------------------------------------------------------------------------------------------------------------------------	----------------------------------------------------------

If yes give details.....

.....

.....

Declaration

Please tick the relevant boxes and sign below

- The information I have provided on my impairment or health condition is **correct** to the best of my knowledge and belief.
- I consent to my information being held and processed by OH as described above under 'Data Protection Information'.

Signed:

Date: