ST. ANDREW'S COLLEGE
Cambridge

MEDICAL QUESTIONNAIRE

Student Details

First Name	
Date of Birth	
Nationality	
Male ☐	Female ☐
Emergency Number *(Please indicate all codes, including country code)*	

Only non-smoking students are allowed to live in halls of residence. If a student starts smoking or is found smoking after arrival they will be removed from halls of residence and will not receive a refund of accommodation fees.
Please confirm that your son /daughter (in the case of over 18s) are a non- smoker.

DO YOU SMOKE?	**Yes** ☐	**No** ☐

Prescription Medication

Does your child take any regular medication (which he/she will bring with him/her?)	Yes ☐	No ☐
If yes, please give details:		
I would like St. Andrew's staff or the homestay host to administer my child's medication and give my consent for them to do so.	☐	
I believe my child is able to administer their own medication and give my consent for them to do so.	☐	

Emergency Medical Treatment

In case of a medical emergency, every effort will be made to contact the child's parent or guardian as quickly as possible. If your child needs an emergency operation, do you give permission for the Director of the school to sign the necessary consent form?	Yes ☐	No ☐
If you have ticked No, please advise what action should be taken?		

Learning Difficulties

Does your child have any specific learning difficulty? eg dyslexia, dyspraxia, attention deficit disorder or dyscalculia	Yes ☐	No ☐
If yes, please give details:		

Medical History

Please answer all of the following questions by ticking the box	Yes	No
Are you regularly attending a hospital, community clinic or seeing a doctor?	☐	☐
Are you suffering from or have you ever suffered from:		
Any conditions relating to your heart or circulation?	☐	☐
Any respiratory problems (eg asthma)?	☐	☐
Any psychological problems (eg: eating disorder / depression / self-harm)?	☐	☐
Any eyesight problem that cannot be corrected by wearing spectacles or contact lenses?	☐	☐
Any ongoing hearing problems or ear disorders (eg tinnitus)?	☐	☐
Any ongoing bone, muscle or joint problems (eg recurrent back pain / arthritis)?	☐	☐
Any skin diseases or conditions that require medical treatment?	☐	☐
Any gastro-intestinal or abdominal problems (eg hernia / gall stones)?	☐	☐
Any blood or metabolic disorders (eg diabetes / anaemia)?	☐	☐
Any neurological conditions (eg severe headaches / epilepsy / vertigo)?	☐	☐
Any long term or debilitating illness (eg multiple sclerosis)?	☐	☐

If you have answered YES to any of the above questions, you must now complete the remaining sections.

If you have answered NO to all the above questions, please sign and date at the end of the questionnaire.

	Heart and Circulation	Yes	No	Details
A	Heart attack	☐	☐	
B	Angina	☐	☐	
C	Other heart disease or abnormal heart rhythm	☐	☐	
D	Chest pain	☐	☐	
E	Stroke / mini stroke	☐	☐	
F	High blood pressure	☐	☐	
G	Palpitations	☐	☐	
	Respiratory	**Yes**	**No**	**Details**
A	Shortness of breath or coughing	☐	☐	
B	Bronchitis	☐	☐	
C	Asthma	☐	☐	
D	Any other lung disorder	☐	☐	
E	Do you smoke?	☐	☐	
	Psychological Health	**Yes**	**No**	**Details**
A	Nervous breakdown, panic attacks, phobias, neurosis	☐	☐	
B	Psychosis, schizophrenia, obsessive/compulsive disorder	☐	☐	
C	Anxiety or depression	☐	☐	
D	Severe stress	☐	☐	
E	Eating disorder	☐	☐	
F	Have you ever tried to harm yourself?	☐	☐	
	Eyesight	**Yes**	**No**	**Details**
A	Eye disease, infection, inflammation, bleeding	☐	☐	
B	Glaucoma, disease of the retina	☐	☐	
C	Have you undergone any eye surgery	☐	☐	

	Hearing	Yes	No	Details
A	Are you aware of any hearing problems?	☐	☐	
B	Non infective ear disorder tinnitus, vertigo?	☐	☐	
C	Infective ear disease (eg discharge, glue ear)	☐	☐	
D	Hearing loss	☐	☐	
	Gastro-intestinal / abdominal	**Yes**	**No**	**Details**
A	Hernia	☐	☐	
B	Bowel problems (eg colitis, chronic diarrhoea, irritable bowl syndrome, Crohn's	☐	☐	
C	Gall stones, pancreatitis	☐	☐	
D	Jaundice or hepatitis A	☐	☐	
E	Kidney problems, renal stones	☐	☐	
F	Chronic indigestion, stomach, peptic or duodenal ulcers	☐	☐	
G	Infections (eg typhoid, paratyphoid fever, salmonella, cholera)	☐	☐	
H	Recurring abdominal pains, gynaecological problems	☐	☐	
I	Severe problems with appetite or digestion	☐	☐	
J	Frequent need for the toilet or incontinence	☐	☐	
	Blood / metabolic disorder	**Yes**	**No**	**Details**
A	Any blood disorder, disorder of lymph glands, anaemia, leukaemia	☐	☐	
B	Any congenital disorder manifested through the blood?	☐	☐	
C	Any disease carried through the blood (eg hepatitis B)	☐	☐	
D	Thyroid, pituitary or hormone disorder	☐	☐	
E	Diabetes melitus If yes, do you require insulin injections on a strict timetable	☐	☐	

	Neurological	Yes	No	Details
A	Headaches, cluster headaches, migraines If yes, please indicate severity (mild, moderate or severe, and how often you get them)	☐	☐	
B	Severe head injury / concussion	☐	☐	
C	Fits, blackouts, fainting, loss of balance, double vision, vertigo	☐	☐	
D	Epilepsy	☐	☐	
	General Medical	**Yes**	**No**	**Details**
A	Cancer	☐	☐	
B	Have you ever had a tropical disease (eg malaria)?	☐	☐	
C	Other debilitating illnesses (eg multiple sclerosis, Parkinson's disease) If yes, please give details	☐	☐	
D	Do you suffer from any medical condition affecting your sleep? If yes, please give details	☐	☐	
E	Have you ever had any medical condition not mentioned above that has involved your GP, a hospital or specialist If yes, please give details	☐	☐	
F	Allergies If yes, please give details	☐	☐	
G	Operations If yes, please give details	☐	☐	
H	Are you currently taking any prescribed tablets or medication or receiving injections If yes, please specify type and timetable	☐	☐	

I certify that I have answered all the questions to the best of my ability and knowledge.

This should be signed by the parent where the student is under 18.

Print Name:

Signed: Date: