

MEDICAL DETAILS FORM

It's best to use the **Word** version of the medical details form. Most people should be able to edit the form fields in that document, save it, and return it to us by email.

But if your computer hardware doesn't let you fill in the form fields in the Word document, then you could print this pdf, complete it in block capitals by hand, then scan it and return it to us by email.



MEDICAL DETAILS FORM

You **must complete parts A to C** of this form and return it to your Hall office within 7 days of the date we sent it to you by email. Completion of **parts D and E** is optional, but strongly recommended. If things change during the year, please let us know.

After you arrive in Hall, we very strongly advise you to register with a local doctor (general practitioner / primary care physician) within central London who will visit you at your hall of residence in an emergency. Then please provide details of your new London GP to your Hall office (ask them to update this form). This advice is based on national guidance from Universities UK. Students who do not register with a local doctor often encounter problems and delays in obtaining treatment.

PART A: YOUR PERSONAL DETAILS

First name

Last name

Date of birth

Hall

- COLLEGE INTERNATIONAL
 CONNAUGHT LILLIAN PENSON
 GARDEN HALLS NUTFORD HOUSE

Room number

Leave room no. blank if you don't know it yet

Mobile phone number

PART B: YOUR GENERAL PRACTITIONER (GP)

GP's name

GP's address

Telephone number

In an emergency, will this doctor visit you at your Hall? YES NO

PART C: SPECIAL ACCOMMODATION REQUIREMENTS

Do you have any diagnosed condition or disability that might affect what type of room you can stay in?

YES NO

If **YES**, please tell us what your condition or disability is and what special requirements you might have for your accommodation as a result.

We cannot guarantee that we will be able to meet all special requirements, but we will discuss them with you and talk you through the options available.

PART D: MEDICAL HISTORY

Medical conditions or disabilities

Long-term medication taken

Hospital(s) that usually treat you

ALLERGIES

PART E: NEXT OF KIN / EMERGENCY CONTACT

Emergency contact name

Relationship to you

Telephone number

Email address

BY COMPLETING PARTS D AND E, YOU GIVE US PERMISSION TO PASS ON THAT INFORMATION TO APPROPRIATE HEALTHCARE PROFESSIONALS IN THE EVENT OF AN EMERGENCY, IF YOU ARE TOO UNWELL TO PROVIDE THE INFORMATION YOURSELF.