All information given in this form will be treated as confidential

| Name |  |
| --- | --- |
| Chosen Name |  |
| Date of Birth |  |
| Do you have any medical coniditions? If yes, please list below  |
|  |
| Do you have to take any medication on a regular basis If yes, please give full details |
|  |
| Do you have any other health conditions that may affect your studies at this time? (please include Physical, Mental, Emotional). Also add here if you have any additional learning requirements. |
|  |
| Do you have any allergies? |
|  |
| Do you have any previous medical history which could be relevant to receiveing health care, if needed, whilst in the UK? |
|  |

**Vaccination history: please attach a copy of your translated childhood vaccinations record (you will need this to register with a General Practitioner in the UK)**