

# دار العلوم دعوة الايمان

## DARUL ULOOM DAWATUL IMAAN

Registered Office: Harry St, Off Wakefield Rd, Bradford, BD4 9PH,

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... Today's students, Tomorrow's leaders ...

### MEDICAL FORM

*Private & Confidential*

#### Applicant Details

Forename: \_\_\_\_\_ Surname: \_\_\_\_\_

Date of Birth: \_\_\_\_\_ NHS No: \_\_\_\_\_

Address: \_\_\_\_\_

*Street Address*

\_\_\_\_\_  
*Town/City*

\_\_\_\_\_  
*Postcode*

Home Tel No: \_\_\_\_\_ Mobile No: \_\_\_\_\_

Emergency Contact Name: \_\_\_\_\_ Relation to Applicant: \_\_\_\_\_

Home Tel No: \_\_\_\_\_ Mobile No: \_\_\_\_\_

#### Medical Details

**(To be completed by GP)**

Name of G.P: \_\_\_\_\_

Address: \_\_\_\_\_

*Street Address*

\_\_\_\_\_  
*Town/City*

\_\_\_\_\_  
*Postcode*

G.P's Tel No: \_\_\_\_\_ G.P's Fax No: \_\_\_\_\_

1. Does the applicant suffer from any serious or long term illness? (e.g. Epilepsy, Bronchitis, Frequent Headaches, Diabetes, Hepatitis, Anaemia etc.)

\_\_\_\_\_

\_\_\_\_\_

2. Does the applicant suffer from any allergies? (If YES, please give details) YES  NO

\_\_\_\_\_

\_\_\_\_\_

3. Does the applicant suffer from any physical or Mental Disability? (If YES, please give details) YES  NO

\_\_\_\_\_

\_\_\_\_\_

4. Is there any family history of the following? (Please Tick)

Heart Disease  Stroke  Asthma  Epilepsy  Cancer   
Diabetes  Angina  High Blood Pressure  Tuberculosis  Other: \_\_\_\_\_

5. Has the applicant ever been to hospital for any form of surgery? (If YES, please give details) YES  NO

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6. Is the applicant receiving any regular/temporary medication at present? YES  NO   
(If YES, please give details)

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7. Does the applicant have any special dietary requirement? \_\_\_\_\_

8. Has the applicant been immunised for the following diseases? (Please tick appropriate box and give dates)

Diphtheria <input type="checkbox"/>	Date: _____	Pneumococcal Infection <input type="checkbox"/>	Date: _____
Tetanus <input type="checkbox"/>	Date: _____	Measles, Mumps & Rubella <input type="checkbox"/>	Date: _____
Whooping Cough <input type="checkbox"/>	Date: _____	Cervical Cancer <input type="checkbox"/>	Date: _____
Polio <input type="checkbox"/>	Date: _____	Meningitis C <input type="checkbox"/>	Date: _____
Hib <input type="checkbox"/>	Date: _____		

9. Height of Applicant: \_\_\_\_\_ Weight of Applicant: \_\_\_\_\_

10. Does the applicant smoke? YES  NO

11. Does the applicant receive or had any treatment for abuse of Substances/Drugs? YES  NO   
(If YES, please give details)

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GP or his/her representative's Signature or Stamp:

Signed: \_\_\_\_\_

Date: \_\_\_\_\_

