# UNIVERSITY OF MALTA
## School of Performing Arts
### Department of Dance Studies

# Medical Form for Prospective Students Bachelor in Dance Studies (Honours)

**Please complete the following form giving as much detail as possible.**
**If there is not enough space, please attach additional sheets. Completion of this form is a necessary part of considering an applicant's readiness to engage in an intensive programme of physical training, and helps to highlight any issues which the Dance Studies course team and university should be aware of.**

**Full name:**
**Sex:**
**Date of birth:**
**Height:**
**Weight:**

It is essential that candidates complete question 1 with as much detail as possible, adding additional sheets where necessary, as this information is particularly relevant to the course.

**1.** Records of broken bones, injuries, strains, and joint or spine disorders and details of treatment:

| Condition | Date | Treatment |
|---|---|---|
| | | |

NOTE: Candidates are asked to provide any MRI / X-ray reports if there have been any significant findings.

2. Have you had any operations?

If Yes, please provide details of dates and operations:

3. Do you have or have you had any of the following conditions, illnesses or allergies (please tick the box where appropriate):

| **Condition** | **Tick** | **Condition** | **Tick** |
|---|---|---|---|
| Eczema | | Epilepsy | |
| Asthma | | Diabetes | |
| Skin conditions | | Glandular fever | |
| Allergies | | Heart conditions | |
| Ear conditions | | Polio | |
| Eye conditions | | Rheumatic fever | |
| Migraines | | | |

If you have ticked any boxes in the table above, please provide details of the condition(s) including any medication you may be taking:

4. Have you had an anti-tetanus injection (circle where appropriate)?

Yes No Date:

5. Has there been any exposure to tuberculosis (circle where appropriate)?

Yes No

If Yes, please give details:

6. Is there any history of depression, anxiety states or nervous disorders?

If so, please give details:

7. Is there a family history of sudden cardiac death in a child / young adult? If so, please give details of family member, age at death and associated heart condition (if known):

8. Have you had any history of disordered eating or weight trouble - including difficulty in maintaining a steady weight? If so please give details:

9. Female applicants, please indicate if your menstrual cycle is regular. i.e. Approximately every month or around 24-34 days (circle where appropriate)

Yes No

If No, please give details:

10. Please indicate if you take the contraceptive pill (circle where appropriate)

Yes No

If Yes, and it is for any reason other than birth control, please state:

11. Are there any other medical related matters you would like to inform us of, that may be relevant to this application?

**PLEASE ENSURE THAT YOU SIGN THE FOLLOWING DECLARATION**

**DECLARATION**

I believe that the information I have given in this form is accurate, and I understand that I may be required to have this information verified by my doctor as a condition of entry. I also agree that details of my past and present medical history may be made available to the University of Malta authorities.

Name of applicant:

Address:

Signature of applicant: …… Date:

**Please return this form one week before your scheduled audition to:**

**Priscilla Grima**
**Administrator, Dance Studies**
**School of Performing Arts**
**University of Malta**
**Msida Campus, MST2080**
**Malta**
**+356 2340 2430 / 3524**
**priscilla.grima@um.edu.mt**

**Please note:**

**If you are successful and a place to study on the course is offered to you, this form will be returned to you for verification by your doctor. This will be a condition of your acceptance to the course.**

**<u>The section below is for candidates who are offered a place on the Bachelor in Dance Studies (Honours) degree course, University of Malta</u>**

Please ask your doctor to verify or, if necessary, **add** to the information given in this form, so that we have an accurate record of your medical history.

**Doctor verification:**

We would be most grateful if you could verify the responses to this questionnaire are correct:

Name of Doctor:

Address of Practice:

Signature of Doctor: ……

Date:

Practice stamp if available:

DATA PROTECTION

The information supplied on this form will be used by the University of Malta for the said purpose and within the terms of the Data Protection Act [Chapter 440, Laws of Malta].