

NEW ZEALAND SCHOOL OF DANCE MEDICAL FORM

To be completed by a registered medical practitioner preferably familiar with the applicant’s case history. A parent or guardian must countersign this form if the applicant is under the age of 18.

Name: _____

Date of Birth: _____ Age: _____ Male Female Other

As part of our commitment to student support and wellbeing, the information collected from this questionnaire will help best assist us to provide adequate support and resourcing to the applicant, should they be accepted into the School. It is important that the applicant discloses any relevant information to ensure the safety and wellbeing of themselves and other students.

Please complete the questions truthfully, and where necessary, kindly include any accompanying documentation, letter from doctor/support team, etc.

1. How long has the applicant been your patient? _____

2. Does the applicant have or has the applicant ever had any of the following?

(please tick appropriate boxes)

	Yes	No	Year		Yes	No	Year
Epilepsy	<input type="checkbox"/>	<input type="checkbox"/>	_____	Concussion	<input type="checkbox"/>	<input type="checkbox"/>	_____
Diabetes	<input type="checkbox"/>	<input type="checkbox"/>	_____	Heart Problems	<input type="checkbox"/>	<input type="checkbox"/>	_____
Hernia	<input type="checkbox"/>	<input type="checkbox"/>	_____	Asthma/Bronchitis	<input type="checkbox"/>	<input type="checkbox"/>	_____
Glandular Fever	<input type="checkbox"/>	<input type="checkbox"/>	_____	Chronic Fatigue Syndrome	<input type="checkbox"/>	<input type="checkbox"/>	_____
Hepatitis A	<input type="checkbox"/>	<input type="checkbox"/>	_____	Covid	<input type="checkbox"/>	<input type="checkbox"/>	_____
Hepatitis B	<input type="checkbox"/>	<input type="checkbox"/>	_____	Post Covid Symptoms	<input type="checkbox"/>	<input type="checkbox"/>	_____

If yes to any of the above, please describe ongoing symptoms, treatments, findings, health concerns or medications required by the applicant for this condition:

3. Does the applicant have any eye concerns / problems? Yes No If yes, please describe:

• Does the applicant wear glasses? Yes No

• Does the applicant wear contact lenses? Yes No

4. Does the applicant have any hearing concerns / problems? Yes No If yes, please describe:

5. Does the applicant smoke or vape? Yes No

6. Does the applicant have or has the applicant ever had any of the following?
(please tick appropriate boxes)

	Yes	No		Yes	No		Yes	No
Anxiety	<input type="checkbox"/>	<input type="checkbox"/>	Bipolar	<input type="checkbox"/>	<input type="checkbox"/>	Other	<input type="checkbox"/>	<input type="checkbox"/>
ADD / ADHD	<input type="checkbox"/>	<input type="checkbox"/>	Depression	<input type="checkbox"/>	<input type="checkbox"/>			

If yes to any of the above, what treatment has been offered?

7. Does the applicant have any allergies to the following items:

	Yes	No	If yes, please list medication or indicate reactions: _____ _____ _____ _____ _____
Food	<input type="checkbox"/>	<input type="checkbox"/>	
Medicine	<input type="checkbox"/>	<input type="checkbox"/>	
Pollen	<input type="checkbox"/>	<input type="checkbox"/>	
Dust mites	<input type="checkbox"/>	<input type="checkbox"/>	
Bees/Insects	<input type="checkbox"/>	<input type="checkbox"/>	
Epipen for allergies	<input type="checkbox"/>	<input type="checkbox"/>	

8. Has the applicant ever had any muscular and/or skeletal problems: Yes No If yes, please describe in more detail:

9. Physical Examination: Normal Abnormal Comments:

Ears /Nose /Throat	<input type="checkbox"/>	<input type="checkbox"/>	_____
Respiratory	<input type="checkbox"/>	<input type="checkbox"/>	_____
CVS	<input type="checkbox"/>	<input type="checkbox"/>	_____

Abdomen	<input type="checkbox"/>	<input type="checkbox"/>	_____
Spine	<input type="checkbox"/>	<input type="checkbox"/>	_____
Extremities	<input type="checkbox"/>	<input type="checkbox"/>	_____
Skin	<input type="checkbox"/>	<input type="checkbox"/>	_____
Neurological	<input type="checkbox"/>	<input type="checkbox"/>	_____
Behavioural	<input type="checkbox"/>	<input type="checkbox"/>	_____
Urinalysis	<input type="checkbox"/>	<input type="checkbox"/>	_____

Height (cm): _____ Weight (kgs): _____ B/P: _____

Are there, or has there been any concerns regarding eating behaviours:

(References: Heijura et al 2018; 4 Mallison et al 2014; O'Donnell et al 2004; Tornberg et al 2017)

Menstrual status in females is a sensitive and objective indicator of Low Energy Availability and is linked to the clinical outcome of impaired bone health and potential stress fractures – RED-S (Relative Energy Deficiency Syndrome).

Extensive scientific literature demonstrates adverse health outcomes of a low oestrogen state in terms of impaired bone, cardiovascular and neuromuscular function.

It is therefore of utmost importance for the health team at NZSD to be aware of the menstrual status of applicant, to optimise wellbeing and the ability to cope with the intensive physical demands of full-time training.

10. Menses history

- At what age did the applicant start menstruating? _____
- Do they have regular cycles? Yes No If not, how long ago was their last period?

- In the past three years, have they had any episodes without a period for 3 months or more: Yes No
- On average, over the past three years, how many periods did they have a year? _____
- Do they take any medication to regulate their cycles? Yes No
- Do they take any medications to control painful cycles? Yes No

Please describe any findings or health concerns or conditions that may require treatment:

11. Have you, as the medical assessor ever had any concerns with this patient about risks such as self harm or suicide? If yes, what treatment has been offered.

Are you aware of any medical condition or injury that may impair the applicant’s ability to complete a professional dance course?

12. Name of medical assessor:

Date of assessment: _____ Phone (bus): _____

Qualification: _____

Address: _____

Email: _____

Signed: _____

DISCLAIMER

I understand that the results of this examination, may be discussed by the above-signed medical practitioner with the staff undertaking the auditions for the New Zealand School of Dance

Applicant’s signature: _____ Date: _____

Parents /Guardian’s signature: _____ Date: _____

(Required only if applicant is under the age of 18 years)

Only the medical officer and relevant staff of the New Zealand School of Dance will see this confidential document.