NEW
ZEALAND
SCHOOL
OF
DANCE
Kia kōrero te katoa
o te tinana

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	☐	☐	________	Concussion	☐	☐	________
Diabetes	☐	☐	________	Heart Problems	☐	☐	________
Hernia	☐	☐	________	Asthma/Bronchitis	☐	☐	________
Glandular Fever	☐	☐	________	Chronic Fatigue Syndrome	☐	☐	________
Hepatitis A	☐	☐	________	Covid	☐	☐	________
Hepatitis B	☐	☐	________	Post Covid Symptoms	☐	☐	________

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

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____

____

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:

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5. Is the applicant a smoker? Yes ☐ No ☐

6. Does the applicant have any emotional concerns? If yes, please provide some detail?

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

	Yes	No	If yes, please list medication or indicate reactions:
Food	☐	☐	
Medicine	☐	☐	
Pollen	☐	☐	
Dust mites	☐	☐	
Bees/Insects	☐	☐	
Epipen for allergies	☐	☐	

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	☐	☐	
Respiratory	☐	☐	
CVS	☐	☐	
Abdomen	☐	☐	
Spine	☐	☐	
Extremities	☐	☐	
Skin	☐	☐	
Neurological	☐	☐	
Behavioural	☐	☐	
Urinalysis	☐	☐	

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

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

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(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 imparied 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 impared 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:

____

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11. Have you, as the medical assessor ever had any concerns with this patient about risk?

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

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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.

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