REGISTRATION FORM: MEDICAL SERVICES  
STRICTLY CONFIDENTIAL

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| Guidelines for using this form |
| 1. This form is for completion by a UCT student wanting to access medical services at the DSA Student Wellness Service (SWS) for the first time. 2. Please email the completed form to [sws@uct.ac.za](mailto:sws@uct.ac.za?subject=Confidential:%20DSA-SWS-ADM009:%20Registration%20form:%20Medical%20services). |

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| SECTION A: STUDENT APPLICANT DETAILS (Note: To be completed by the student) | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Student Title, Name and Surname | | | | | | | | |  | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Student Number |  | | |  |  | |  |  | | |  |  | | |  | |  | | | Age | | | |  | | | | Date of Birth | | | | | | | | |  |  |  |  |  |  |  |  | | --- | --- | --- | --- | --- | --- | --- | --- | | D | D | M | M | Y | Y | Y | Y | | | |  | |  |  | |  |  |  |  |
| Faculty |  | | | | | | | | | | | | | | | | | | | Course of Study | | | | | | | | | | | |  | | | | | | | | | | | | | | | |
| Year of Study |  | | | | | | | | | | | | | | | | | | | First Year of Registration | | | | | | | | | | | | | | |  | | | | | | | | | | | | |
| Sex (please tick one) | | | | | | Male | | | | | | |  | | | | | | | | | Female | | | | | | |  | | | | | | | | | Trans | | | | |  | | | | |
| Telephone No. | | | | | | Term No. | | | | | | |  | | | | | | | | | | | | | | | | | Cell No. | | | | | | |  | | | | | | | | | | |
| UCT Email Address | | | | | |  | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| University Term / Physical Address (in Cape Town) | | | | | |  | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Next of Kin / Person to be contacted in an emergency | | | | | | | | | | | | | | | | | | |  | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Next of Kin Contact No. | | | | | |  | | | | | | | | | | | | | | | | Next of Kin Relationship | | | | | | | | | | | | | | | |  | | | | | | | | | |
| Do you receive financial aid from NSFAS?  (Note: Bursaries and scholarships are not included.) | | | | | | | | | | | | | | | | | | Yes | | | | |  | | | No | | | |  | | |  | | | | | | | | | | | | | | |
| If yes, please send a copy of the letter to [sws@uct.ac.za](mailto:sws@uct.ac.za) so that consultation fees can be waivered | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Are you on Medical Aid? | | | | | | Yes | | | |  | | | No | | |  | | | | | Name of Medical Aid | | | | | | | | | | | | |  | | | | | | | | | | | | | |
| Membership No. | |  | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Main Member | | Name and Surname | | | | | | | | | | |  | | | | | | | | | | | | | | | | | | Contact No. | | | | | | | | | |  | | | | | | |
| List any serious medical / psychological conditions / disabilities that you suffered previously or currently | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
|  | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| List any surgery / operations | | | | | | | | | | | | | | | |  | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
|  | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| List any medication you are taking presently | | | | | | | | | | | | | | | |  | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
|  | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| List any medication that you are allergic to | | | | | | | | | | | | | | | |  | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
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| SECTION B: STUDENT AGREEMENT (Note: To be completed by the student) | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| I understand the following:   * There are certain charges for consultations, procedures, materials and medical tests * There are also charges for any referrals outside of student health, including transportation. * I’m personally responsible for enquiring about any charges * Clinical health professionals share medical records for the purpose of providing holistic health care * By submitting this form electronically, I accept the terms and conditions on the registration form | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Student Signature | | |  | | | | | | | | | | | | | | | | | | | | | | Date | | | | | | |  | | | | | | | | | | | | | | | |
| FOR OFFICE USE ONLY | | | | | | Capture Date | | | | | | | |  | | | | | | | | | | | | | Admin Signature | | | | | | | | | | | | |  | | | | | | | |
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