Health Declaration

I declare that I understand, accept and confirm the entitlement of The Agency to reject my application or offer you Agency shifts where I have omitted to furnish the Agency with any information relevant to this health assessment or where I have made any false statement or misrepresentation relevant to this health assessment.

Full Name _____

Phone Number _____

Please answer **YES** or **NO** by ticking the appropriate box and if ticked **YES**, please give details in the space provided.

		Yes	No	Details
1	Do you have, or have you ever had, any medical conditions or surgery in the past 5 years?			
2	Are you at present attending a doctor for medical care, taking any medication or on a waiting list for hospital assessment or treatment?			
3	Have you ever suffered a work related illness, or given up work due to ill health?			
4	Do you have impairment / disability (physical or mental) or specific learning disability which may affect your ability to work?			
5	Have you ever suffered from tuberculosis (TB)? Within the past 12 months			
	Has any family member or close contact been treated for TB?			
	Have you had a cough for more than 3 weeks?			
	Have you coughed up blood?			
	Have you had any unexplained weight loss?			
	Have you suffered from night sweats or fever?			
6	Have you ever had any kind of back, joint or muscle problem?			
7	Have you ever had: Dermatitis, Eczema, Psoriasis or any other skin condition?			
8	Have you ever had any mental illness which might affect your ability to work? (including anxiety, depression, self-harm, eating disorders, psychological or emotional problems)			
9	Have you ever had a drug or alcohol problem?			
10	Do you have any difficulty with your eyesight (including colour blindness)?			
11	Do you have difficulty with your ears or hearing?			

12	Have you ever suffered from any of the following; loss of consciousness including fainting attacks, blackouts, dizziness, epilepsy?			
13	Have you ever suffered from any of the following; heart disease or circulatory problem; including high blood pressure, varicose veins			
14	Have you ever suffered with chest or lung problems; Asthma, Bronchitis?			
15	Have you any allergies; including allergies to drugs, food or latex?			
16	Have you ever received treatment for bowel or gastric problems?			
17	Have you ever suffered a disorder of the bladder or kidneys?			
18	Do you have any other medical condition not previously mentioned in questions 1 – 17 above?			

Previous Sickness Absence – time lost from work due to illness over last 2 years.

Length of absence	**Reason for absence**

Signed _____

Print Name _____

Date _____

GP Name	
GP Address	
GP Telephone	

Vaccination / Immunity Status History

All health care workers with patient contact are required to provide information relating to their immunity to TB, Mumps, Measles, Rubella, Varicella and Hepatitis B (anti-HBs). Please include copies of previous laboratory test results.

To be completed and stamped by an Occupational Health Professional / General Practitioner.

Full Name _____ Date of Birth _____

The above person has the following vaccinations carried out. Immune Yes (**Y**) / No (**N**)

Hepatitis B 1st Date _____ 2nd Date _____ 3rd Date _____ Y ☐ N ☐

Hepatitis B Titre Date _____ Result _____ mIU/ml

Hepatitis B Booster Date _____

Hepatitis B Titre Date _____ Result _____mIU/ml

Measles (Serology) Date _____ Result _____ Y ☐ N ☐

Mumps (Serology) Date _____ Result _____ Y ☐ N ☐

Rubella (Serology) Date _____ Result _____ Y ☐ N ☐

Varicella (Serology) Date _____ Result _____ Y ☐ N ☐

Mantoux Test 2TU Date _____ Result _____

Mantoux Test 10TU Date _____ Result _____

BCG Scar Check Date _____ Location _____

TB Status Date _____ Y ☐ N ☐

Completed by:

Signature _____

Title _____

Facility _____

Date Completed _____

OFFICIAL STAMP