**NHS HIGHLAND OCCUPATIONAL HEALTH SERVICE**

**HEALTH DECLARATION FORM – IN CONFIDENCE**

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| **EMPLOYEE DETAILS** |
| **Full Name:** | **Job Title:** |
| **Job Reference:**  |
| **Title:** | **N.I. Number:** |
| **Date of Birth:** | **E-mail Address:** |
| **Telephone Number:** | **Mobile Number:**  |
| **Address:****Postcode:** | **GP Practice:****Address** |

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| **EMPLOYMENT HISTORY:** To assist us assess your Occupational Health needs, please list your previous jobs and exposure to hazards e.g. sharps injury, moving and handling, exposure to dust/chemicals/noise: |
| **Job Title** | **Employer/Training Organisation** | **From** | **To** | **Injury/Hazard** |
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| MEDICAL INFORMATION | **Yes** | **No** |
| 1. Do you have any medical condition, physical or psychological? If yes give details below
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| 1. If yes to above, does this condition interfere with your ability to attend work or perform the duties of your role?
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| 1. Are you waiting for treatment (including medication) or investigation at present? If yes give details below
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| 1. Do you require any workplace adjustments or support to enable you to undertake the post? If yes give details below
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| 1. Are you currently receiving any treatment, medication, have any active implanted or body worn medical devices e.g. insulin pump, pacemaker or receiving specialist support?
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| 1. Have you had a condition affecting your skin in the last two years? If yes give details below
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| 1. Have you ever been diagnosed with Tuberculosis

orDo you have symptoms which may be due to Tuberculosis e.g. an unexplained persistent productive cough, shortness of breath, fatigue, weight loss or night sweats? |  |  |
| 1. Have you been in contact with an individual with active open Tuberculosis or returned from a country where Tuberculosis incidence is > 40 per 100,000 per year?
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| **Please use the space below to provide further information on your answers:** |

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| The Occupational Health Service may contact you via e-communications. Please tick if you **DO NOT** wish to receive e-communications from Occupational Health e.g. text appointment reminders, links to annual patient satisfaction questionnaire [ ] Your details will not be shared with any third party  |

**DECLARATION** I declare that the information and statements given on this form are true and complete to the best of my knowledge. I am aware that any false statements may affect my application. I give my consent to health assessment and/or medical examination if necessary. I understand that no medical details will be divulged without my permission to any person outwith the Occupational Health Service. However, an opinion about my fitness for the post will be given to the Recruiting Officer.

**Signature:** ……………………………………………… **Date:** …………………………

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| **IMMUNISATIONS**To avoid any delays in your clearance, documentary evidence of previous immunisations /blood tests must be submitted to Occupational Health along with your completed health declaration form. This information can be obtained from your GP Practice or previous OH provider.**N.B. we will not contact your GP or previous Occupational Health provider to obtain this information.** |
| **Please provide documentary evidence for the following**

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| **Routine Immunisations** | **EPP Workers (IVS Samples only)** |
| Hepatitis B | \*\* HIV |
| Measles, Mumps, Rubella (MMR) | \*\* Hepatitis C Antibody |
| BCG | \*\* Hepatitis B Surface Antigen |
| Diphtheria, Tetanus, Polio, Pertussis | \*\* Hepatitis B Antibody |
| \*Typhoid |  |
| \*Hepatitis A |  |

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\* Laboratory and maintenance workers only

\*\* Exposure Prone Procedure (EPP) workers only

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| **Have you had chickenpox or shingles?** | **Yes** |  | **No** |  |
| **Have you had a BCG vaccination?** | **Yes** |  | **No** |  |
| **Do you have a BCG scar?**  | **Yes** |  | **No** |  |

Do you consent for us to access any previous records which may be held by NHS Highland Occupational Health Department (e.g. clinical information from your student records or from a previous employment within NHS Highland) **Yes** [ ]  **No** [ ]

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| I can confirm that the information provided above it correct to the best of my knowledge. If I have chosen to decline any of the vaccinations offered above I understand that I may contact the Occupational Health Service at any time if I wish to be vaccinated in the future.I also give consent for a record of my declined vaccinations to be forwarded to my line manager so that he or she may take this information into account when considering any risk assessments |

**Signature…………………………………………………….. Date…………………………….**

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| **QUESTIONAIRE: please provide further details in the comments section for a YES response.**  | **YES** | **NO** | **COMMENTS** |
| 1 | Have you suffered from diarrhoea and/or vomiting in the past seven days? |  |  |  |
| 2 | At present are you suffering from: |  |  |  |
| Skin trouble affecting hands, arms or face?  |  |  |  |
| Boils, styes or septic fingers?  |  |  |  |
| Discharge from eye, ear or gums/mouth?  |  |  |  |
| Recurrent skin or ear trouble?  |  |  |  |
| Recurrent bowel disorder?  |  |  |  |
| Do you have any known food allergies?  |  |  |  |
| 3 | Have you ever had Typhoid or Paratyphoid?  |  |  |  |
| 4 | In the last 21 days have you been in contact with anyone, at home or abroad who may have been suffering from Typhoid or Paratyphoid? |  |  |  |
| 5 | Do you have a colostomy, or ileostomy? |  |  |  |

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| **SIGNATURE** |  | **DATE** |  |