**Confidential Pre-Placement Health Questionnaire**

**Please read this form all the way through before starting to complete it.**

Your placement is subject to satisfactory health clearance which requires you to complete this form and return alongside your application form.

The purpose of the health assessment is to ensure, so far as is possible, that you are fit for the placement you have applied for in order to protect your own and others health and safety. Occupational Health will use this information to review whether any adjustments will be required to make your placement an informative and beneficial experience. Information given to us about your health is kept in accordance with the Data Protection Act, will remain confidential to the Occupational Health Department and may be kept as part of your Occupational Health Record.

A member of the Occupational Health team may contact you for further information if necessary or you may be offered and appointment for an assessment.

If you have any questions about completing this form, please form not hesitate to contact us on 01553 214885 or 01553 214620.

**I declare that the information I have given is correct to the best of my knowledge. I understand and acknowledge that if it is subsequently discovered that the information given has been falsified in any material particular, or that I have failed to make a full disclosure of the facts required, I will be liable to have my placement terminated.**

|  |  |
| --- | --- |
| **Signature** |       |
| **Print Name** |       |
| **Date** |       |

| **Details** |
| --- |
| **Name** |       |
| **Date of Birth** |       |
| **Address** |       |
| **Telephone Number****(Home & Mobile)**  |       |
| **Email Address**  |       |
| **Position for Placement**  | Work placement – Area TBC |
| **Name and Address of GP**  |       |
| **Have you ever worked for or volunteered for an NHS Trust before?**  | [ ]  Yes (If yes, please give details)[ ]  NoDetails:       |

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| **Health Questions** |
| **Do you have any long term physical or mental impairment that affects your ability to carry out normal day to day activities?**  | [ ]  Yes (If yes, please give details)[ ]  NoDetails:       |
| **Have you had any other serious illness or operations in the past?** | [ ]  Yes (If yes, please give details)[ ]  NoDetails:       |
| **Are you taking or being prescribed any medicines, inhalers, injections or eye/ear drops at the present time?**  | [ ]  Yes (If yes, please give details)[ ]  NoDetails:       |
| **Is your ability to perform physical work limited in any way?** | [ ]  Yes (If yes, please give details)[ ]  NoDetails:       |
| **Have you had or been in contact with any infectious disease in the past four weeks?**  | [ ]  Yes (If yes, please give details)[ ]  NoDetails:       |
| **To protect your health at work please indicate in confidence to Occupational Health if you are pregnant or breastfeeding. (This is in accordance with the Expectant Mothers at work Regulations)**  | [ ]  I am pregnant or breastfeeding[ ]  Not applicable |
| **Have you lived or worked outside the UK in the last 12 months?**  | [ ]  Yes (If yes, please give details)[ ]  NoDetails:       |
| **Do you have or have you had any problems in your neck, shoulders, arms, hands/wrists, back, knees, hips or feet?**  | [ ]  Yes (If yes, please give details)[ ]  NoDetails:       |
| **Do you have any mental health problems eg: depression, anxiety states, eating disorders, self-harm?**  | [ ]  Yes (If yes, please give details)[ ]  NoDetails:       |
| **Epilepsy, dizziness, fits or blackouts?**  | [ ]  Yes (If yes, please give details)[ ]  NoDetails:       |
| **Any chest or cardiac problems or breathing difficulties eg: asthma, wheezing, TB?**  | [ ]  Yes (If yes, please give details)[ ]  NoDetails:       |
| **Any visual or hearing problems?**  | [ ]  Yes (If yes, please give details)[ ]  NoDetails:       |
| **Eczema, dermatitis or other skin conditions?**  | [ ]  Yes (If yes, please give details)[ ]  NoDetails:       |
| **Do you have any allergies to food, medicine or other substances?**  | [ ]  Yes (If yes, please give details)[ ]  NoDetails:       |
| **Please tick if you have had any of the following:**  | [ ]  Shingles[ ]  Chickenpox[ ]  German Measles (Rubella)[ ]  Measles[ ]  Mumps[ ]  Hepatitis A[ ]  Whooping Cough |
| **Do you or have you had a blood borne virus eg: HIV, Hepatitis B, Hepatitis C**  | [ ]  Yes (If yes, please give details)[ ]  NoDetails:       |
| **Any other health conditions (or operations) not specified above (please indicate)**  |       |

**Which of the following infectious disease have you been immunised against?**

(*Tick the relevant boxes and please complete in full*)

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **BCG (Tuberculosis)****[ ]**  | **Pertussis (whooping Cough)****[ ]**  | **Diphtheria****[ ]**  | **Polio****[ ]**  | **MMR****[ ]**  |
| **Rubella****[ ]**  | **Meningitis****[ ]**  | **Tetanus****[ ]**  | **VZ (chickenpox) Vaccine****[ ]**  | **Any other vaccines****[ ]**  |