**Employee Health Declaration Form**

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| **A: Personal Details** | | | | |
| **Name:** | | **Employee Number:** | | |
| **Date of Birth:** | | **Height:** | | |
| **Address 1:** | | **Weight:** | | |
| **Position:** | | **Department:** | | |
| **B: Your Health** | | | | |
|  | **Have you suffered from any of the following during the last 12 months? Tick yes or no. If Yes give details on section D** | | **YES** | **NO** |
| 1 | Epilepsy/ Fit(s) | |  |  |
| 2 | Diabetes (Type I or Type II, please specify) | |  |  |
| 3 | Cardiovascular disease | |  |  |
| 4 | Neurological Deficit | |  |  |
| 5 | Narcolepsy or sleep apnea or any issues with sleeping | |  |  |
| 6 | Stroke | |  |  |
| 7 | Chronic back pain including disc diseases | |  |  |
| 8 | Joint problem that may affect limbs movement | |  |  |
| 9 | Asthma, bronchitis or any other respiratory disease | |  |  |
| 10 | Any blood issues | |  |  |
| 11 | Any chronic skin diseases | |  |  |
| 12 | Eye disease which require long treatment | |  |  |
| 13 | Admission to hospital for 4 days or more | |  |  |
| 14 | Kidney disease (please specify) | |  |  |
| 15 | Cancer | |  |  |
| 16 | Psychiatric Illness | |  |  |
| 17. | Are you pregnant? **If you answer yes** please comply with other requirements stated in the Occupation Health Policy including completion of the Occupational Health Referral form | |  |  |
| 18. | Other: Please give details on separate sheet | |  |  |
| Allergies: | | | | |
| **C: Vaccinations** | | | | |
| I agree to acquire all identified vaccinations and schedule myself as needed Yes □ No □ | | | | |
| All of my identified vaccinations are up to date and have been submitted Yes □ No □ | | | | |
| If no, please explain: | | | | |
| **D: Additional details (To be filled by Employee)** | | | | |
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| **E: Declaration** | | | | |
| I declare that all the above statements are true and complete to the best of my knowledge; I understand that I may be required to undergo a medical examination and consent if required.  Signature: .............................................................................................  Date: .................................................................................................... | | | | |
| **F: Occupational Health Notes** | | | | |
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Medical Director: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date (dd/mm/yy): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Signature & Stamp/ ID