

SHERIDAN

HEALTH CHECK FORM

Please use block capitals throughout. The information provided will be treated as strictly confidential at all times.

FULL NAME: Mr Mrs / Miss / Ms

PLEASE ANSWER THE FOLLOWING QUESTIONS:

If the answer is 'YES', give details including (a) date, (b) the amount of time lost from work / school, (c) treatment, as appropriate.

1. Conditions of the lungs? (e.g. Asthma, Bronchitis)

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2. Conditions of the heart? (e.g. High blood pressure, Heart attacks, Angina)

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3. Nervous system disorder? (e.g. Blackouts, Epilepsy)

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4. Migraine or persistent headaches?

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5. Conditions of the kidney or bladder?

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6. Conditions of the digestive system?

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7. Conditions of the bones, joints and limbs? (e.g. Arthritis, Back problems)

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8. Allergies?

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9. Skin conditions? (e.g. Eczema, Dermatitis)

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10. Gland trouble? (e.g. Diabetes, Thyroid under / over active)

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11. Eye conditions?(e.g. Restricted vision, Glaucoma)

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12. Ear conditions? (e.g. Restricted hearing, Tinnitus)

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13. Alcohol or drug problems?

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14. Mental illness and / or stress related problems?

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15. Have you consulted a specialist or needed any operations other than already stated?

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16. Have you spent any time in hospital other than already stated?

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17. Have you consulted your GP in the last twelve months?

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18. Are you receiving medical treatment at the present time?

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19. Do you take any regular medication?

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20. Do you anticipate that you will need time off work for medical reasons in the next twelve months? If so, please give details:

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21. Have you any other health issues that have not been mentioned above or about which you would like to provide further details?

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Have you a disability? **YES / NO**

If YES, what is the disability?
(‘Disability’ ...a person has a disability if he/she has a physical or mental impairment which has substantial long-term adverse effect on his/her ability to carry out normal day-to-day activities which is likely to last at least 12 months, has lasted 12 months, or is likely to last for the rest of the person’s life.) This question is asked to enable us to identify what adjustments to the working environment may be necessary to help you fulfil the role and/or to work safely.

OTHER INFORMATION:

Please provide any other information concerning your health which you consider would assist us in considering your application:

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DECLARATION:

I hereby confirm that the answers and the information which I have given above are true to the best of my knowledge and that I am prepared to undergo a medical examination if required to do so. I understand that if any information given in this form is in any respect untrue my employment may be terminated.

SIGNED:

DATED: