**HEALTH DECLARATION & ADDITIONAL SUPPORT NEEDS ASSESSMENT FOR STAFF**

Due to the nature of the work that you will undertake with (INSERT SERVICE NAME HERE) and the frequent requirement for a certain level of physical and mental fitness, we require you to provide us with certain details of your medical history as a part of the application process. The information requested here will only be considered in accordance with the provisions of the Equality Act 2010.

Name:

Date:

|  |  |  |  |
| --- | --- | --- | --- |
| Do you suffer/or have suffered from any of the following? Please circle yes or no | If yes please give dates | How do you currently manage this condition?  | **OFFICE USE ONLY** Please consider a separate risk assessment where required and plan of how we (insert service name here) will support you to work safely and manage the risks around this condition |
| Tuberculosis, asthma, bronchitis or any disease of the lungs | Yes | No |  |  |  |
| Asthma/COPD/breathing conditions | Yes | No |  |  |  |
| Heart disease or disorder, strokes or high blood pressure  | Yes | No |  |  |  |
| Rheumatic Fever | Yes | No |  |  |  |
| Osteoarthritis, Rheumatoid Arthritis, or other painful inflammatory conditions | Yes | No |  |  |  |
| Back trouble i.e. slipped disc, lumbago or other mobility difficulties | Yes | No |  |  |  |
| Any neurological disorders e.g. Multiple Sclerosis or Epilepsy | Yes | No |  |  |  |
| Diabetes Type 1 or 2 or any other blood sugar disorders | Ye | No |  |  |  |
| Skin disease e.g. eczema or dermatitis | Yes | No |  |  |  |
| Any known allergies | Yes | No |  |  |  |
| Recurrent stomach troubles, gastric disorders/vomiting | Yes | No |  |  |  |
| Hernia | Yes | No |  |  |  |
| Any hearing defects/difficulties in either ear | Yes | No |  |  |  |
| Eye disease (inc. Colour blindness), visual difficulties  | Yes | No |  |  |  |
| Mental health complaints e.g. depression,Post Traumatic Stress Disorder, Bi-Polar Disorder | Yes | No |  |  |  |
| Stress | Yes | No |  |  |  |
| In addition, have you? |  |
| Had any surgical operations in the last twelve months or are you awaiting any surgical operations or hospital appointments | Yes | No |  |  |  |
| Received medical treatment during the past three months or are you on a waiting list for such treatment | Yes | No |  |  |  |
| Have you got any condition or difficulty with dyslexia or dyscalculia that needs to be considered?  | Yes | No |  |  |  |
| Have you got any other conditions such as ADHD, Autism that may require extra support or adjustments.  | Yes | No |  |  |  |
| Received any immunisation or vaccines in the last twelve months (other than Covid – see below)  | Yes | No |  |  |  |
| Been diagnosed with any contagious illness or disease during the last twelvemonths (including Covid – please provide date)  | Yes | No |  |  |  |
| If you have had Covid, are there any lasting effects that need to be considered?  | Yes | No |  |  |  |
| What is your Covid vaccination status? Please circle vaccinated (and add additional details) or unvaccinated | VaccinatedDate1:Date 2:Type of vaccine: | Unvaccinated |  |

**ADDITIONAL NOTES (if required)**

**Thank you for completing this form**