**PRE-EMPLOYMENT HEALTH DECLARATION**

Please fill in this questionnaire and return it to the employer. All information will be treated as confidential and will be

destroyed at the end of the Production. The information requested will enable the employer to take better care of all

employees.

NAME: \_\_\_\_\_\_\_\_\_\_\_\_\_

ADDRESS: \_\_\_\_\_\_

TELE. NO.: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ MOBILE NO.: \_\_\_\_

AGE: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ BLOOD TYPE: \_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_

NEXT OF KIN: DOCTOR:

ADDRESS: \_\_\_\_ \_ADDRESS:

TELE. NO.:\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_TELE. NO.: \_\_\_\_\_\_\_

ANY ALLERGIES? YES / NO

If yes, please detail any allergies to drugs including drugs such as penicillin, sedatives, antihistamines, aspirin, etc.

Please detail any allergies to other substances including food allergies, allergies to stings (eg, bees, wasps), animals (eg, cats) and environmental allergies (eg, dust mites, pollens, grass seeds). Please note symptoms and preferred method of treatment.

ANY PHYSICAL DISABILITIES OR PRE-EXISTING MEDICAL CONDITIONS? YES / NO

If yes, please provide details (eg, diabetes, asthma, back problems, epilepsy, history of heart problems, pregnancy)

EYESIGHT/HEARING - Please provide details if you have impaired eyesight and/or hearing:

Do you wear glasses/contact lenses/hearing aid?

Do you have specific eyesight problems (eg night blindness, colour blindness, history of recurrent conjunctivitis)?

SPECIAL DIETARY REQUIREMENTS? eg, vegetarian, no milk products or other.

HAVE YOU HAD A TETANUS INJECTION IN THE LAST FIVE YEARS? YES / NO

ARE YOU ON ANY REGULAR MEDICATION AT THIS TIME? YES / NO

If yes, please detail

Signed by the employee .................................................................................

Date .............................................................................................................