Health Declaration for Fera Training Course Participants

For internal use only

HR contact name		Form sent to H&WB		Received by H&WB	

1. Personal Details

Date of Visit		**Host**	Verda Fazlic
Full Name			
Organisation			
Address			
Gender	Male ☐ Female ☐	**Date of birth**	

2. Disability – If you would like Fera to be aware of any disability you may have, this will allow us to make any reasonable adjustments to assist you whilst on site, please complete this section.
Please note this section is not mandatory.

Do you have any disability which may restrict access during your visit, or which requires special arrangements? If **NO**, go to section 3. **YES** ☐ **NO** ☐

If you answered **YES** to the above question, please put a cross in the box(es) that best describe your disability. You may cross more than one box.

Mobility ☐
Difficulty in going up or down stairs, or moving around without assistance

Eyesight ☐
For example, inabilities to read ordinary print, assuming you have the relevant skills, even when wearing spectacles or contact lenses.

Manual dexterity ☐
Loss of function in one or both hands such that it significantly limits the use of a hand or hands; for example, affecting the ability to pick up or manipulate small objects, communicate through writing or typing or operating a range of equipment manually.

Continence ☐
The inability to control bowel or bladder functions.

Lifting/carrying/moving everyday objects ☐
The ability to pick up and carry everyday objects of moderate size and weight with one hand but not the other. Everyday objects might include books, a briefcase, or an overnight bag.

Memory, concentration, learning or understanding ☐
Frequently forgetting the names of familiar people, such as family or friends; this may also cover learning to do things more slowly than usual.

Physical co-ordination ☐

Includes balanced and effective interaction of body movement. For example hand and eye co-ordination. An example would be the ability to pour liquid into a container only with unusual slowness or concentration.

Mental illness ☐

A clinically well recognised mental illness.

Speech ☐

For example, the inability to give clear instructions orally to colleagues; impairments include those which affect the acquisition and effective use of your native language in conversation, for example if you have had a stroke or have a significant speech impediment.

Other ☐

This might include asthma, dyslexia, dyspraxia, epilepsy, diabetes or angina and progressive conditions such as cancer, multiple sclerosis and muscular dystrophy.

(Please give details below)

Hearing ☐

An inability to hear and understand a person talking in a normal voice, with the levels of noise found in an office environment, or an inability to hear and understand another person talking on the telephone.

(Please give details here)

What facilities or arrangements to you need to allow you to visit our site?

3. Respiratory Disorders

Have you ever had a respiratory or lung disorder? – for example asthma, tuberculosis (TB), persistent throat problem, bronchitis, pneumonia, pleurisy or other respiratory condition, cystic fibrosis, etc.? If **YES**, please give details, including dates. If **NO**, please go to next section.

YES ☐ **NO** ☐

Insert details here:

If you have asthma, what are your "triggers"? Please tick all boxes that apply.

Exercise † ☐ Cold conditions ☐ Other (Please name) ☐

Or asthmagens such as:

Insects † ☐ Bee venom ☐ Shellfish † ☐ Pollens ☐ House-dust mites † ☐

Fungal spores ☐ Penicillins ☐ Peanuts † ☐ Latex † ☐ Nickel † ☐

Fruit or vegetables ☐ Prescription medicines † ☐ Other (Please name) ☐

What is your current treatment regime? Such as:

Ventolin ☐ Becotide ☐ Antihistamines ☐ Other (please name) ☐

How often do you use the medication?

Regularly ☐ Seasonally ☐ Infrequently ☐ Stopped using ☐

4. Allergies

Have you ever suffered from any of the following? **YES** ☐ **NO** ☐

If **YES** please indicate and provide details below.

Allergic rhinitis ☐ Allergic conjunctivitis ☐ Eczema ☐ Hayfever † ☐ Urticaria (rashes) † ☐

Dermatitis or Other skin complaint ☐ Insert details here:

YES ☐ **NO** ☐

Are you allergic to any substances such as the following?

If **YES**, please give details including dates. Please note this list is not exhaustive.

Insects ☐ Bee venom ☐ Shellfish ☐ Pollens † ☐ House-dust mites † ☐

Fungal spores ☐ Penicillins ☐ Peanuts ☐ Latex † ☐ Nickel ☐

Fruit or vegetables ☐ Prescription medicines ☐ Other ☐ Insert details here:

5. Chronic Infections

Have you ever had any chronic infections? **YES** ☐ **NO** ☐

For example hepatitis, jaundice, HIV, tuberculosis etc.

6. Pregnancy

Are you pregnant? **YES** ☐ **NO** ☐

7. Dietary Requirements

Please specify any special dietary requirements

Examples may include: Kosher; halal; vegetarian; vegan; gluten free; diabetic

Insert details here:

If you have exclusions for allergies and food intolerance, please give details below:

Insert details here:

8. Other conditions

Do you have any other medical conditions, or are you aware of any other reason, that might put you at risk within a laboratory environment? If **YES**, please give details below: **YES** ☐ **NO** ☐

Insert details here:

8. Signature

Signature:	
Date:	