Oxford College of Education

Health Declaration

PRIVATE & CONFIDENTIAL

The employee of Oxford College of Education is required to complete this Health Declaration. Any positive answers will not necessarily affect your application. Please list any medical conditions (past or present) which may affect your ability to do the job.

Name of Staff:

Position:

Occupational Health Assessment	Yes	No	Details
1. Are you in good health?			
2. How much time have you lost from work due to illness in the last five years? Please provide details			
3. Have you ever been treated in hospital for serious illness or surgery? Please give dates			
4. Have you been treated in hospital during the last 12 months?			
5. Do you have any physical disabilities that could affect your ability to carry out your assignment?			
6. Have you ever left, been retired or denied a job on health grounds?			
7. Have you ever been denied a driving license on health grounds?			
8. Are you a registered disabled person?			
9. Have you any disability related to your physical or mental health?			
10. Have you ever suffered from any mental illness, psychological or psychiatric problems?			
11. Do you get discomfort or pain in the chest or shortness of breath on exercise?			
12. Have you ever had any problems with your joints, including pain, swelling or stiffness?			
13. Do you have any difficulty in moving rapidly over short distances?			
14. Would you have difficulty looking over either shoulder?			
15. Do you need to wear glasses or contact lenses?			
16. Do you have any difficulty with your eyesight which is not corrected by glasses or contact lenses?			
17. Have you any problems working with Visual Display Units?			
18. Have you any problems working in confined spaces/using lifts?			

19. Do you have any difficulty hearing normal conversation?			
20. Are you taking any medication that makes you dizzy or drowsy?			
21. Do you have a medical condition affected by changing sleeping patterns or affecting day time sleep?			
22. Have you suffered from any alcohol or drug related illness or had an alcohol or drug problem?			
23. Are you having or awaiting any treatment at the moment?			
24. What is the date of your last chest x-ray?			
25. Are you receiving Medicines, Pills or Tablets from a doctor or on prescription?			
26. Have you ever suffered from any of the following?			
27. Heart Problems/Circulatory Illness/Hypertension			
28. High or Low Blood Pressure			
29. Diabetes			
30. Asthma/Hay fever			
31. Bronchitis/Pneumonia/Pleurisy			
32. Tuberculosis			
33. Epilepsy/Fainting Attacks/Blackouts/Fits/Sudden Collapse			
34. Headaches/Migraine			
35. Psychiatric Illness/Anxiety/Depression			
36. Dermatitis/Skin Sensitivity/Psoriasis/Eczema/Allergies			
37. Back Injury/Back Problems/Back Pains			
38. Recurrent Infections e.g. Sore Throats/Ear Infections/Eye Infections			
39. Hepatitis/Jaundice			
40. Any other issue (Please write Specifically)			
If you have answered yes to any of the above, please give details in the space provided.			

Signature of employee:

Date: