LONDON QUALITY CARE SERVICES DECLARATION OF HEALTH & MEDICAL FITNESS	LQCS	
	Date reviewed	Sept 2017
	DATE:	

EMPLOYEE DETAILS			
Surname:		Forename(s):	
Address:		Date of Birth:	
		Tel. No:	
GP Name & Address:			

A: Do you have, or have you ever suffered from, the following:				
CONDITION	NO	YES		
Typhoid Fever / Paratyphoid Fever / Enteric Fever?				
Salmonella Infection?				
Dysentery?				
TB (Tuberculosis)?				
Tropical Diseases e.g. Hookworm?				
B: Have you suffered from any of the following in the last 2 years:				
Diarrhoea / Vomiting for more than 2 days?				
Chronic Bronchitis with Phlegm?				
Skin Rash / Eczema / Dermatitis / other Skin Disease?				
Recurrent Boils / Types / Septic Fingers?				
Discharge from the Ear / Eyes / Nose?				
Fits or Blackouts?				

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C: Other:

CONDITION	NO	YES	
		Dates	Details
Have you had treatment for any condition relating to the abuse or misuse of alcohol or drugs within the last 5 years?			
Have you ever had medical insurance refused, or offered subject to special conditions?			
Have you ever suffered from a back strain, or other back conditions which may affect your ability to undertake lifting and handling activities safely?			
Are you pregnant? If yes, state how many months…………………	YES / NO / NA		
Are you prepared to undergo a medical examination?	YES / NO		
Do you give your consent for us to contact your GP?	YES / NO		

Any other relevant information:

I confirm that the answers to these questions are true and accurate to the best of my belief and knowledge. Any information which is deemed to be false or inaccurate will lead to termination of services.

Signature: ____________________ *Full Name (PRINT):* ____________________ *Date:* ________________

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