**Medical Questionnaire**

Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date of Birth:\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Post applied for:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Occupational Health may contact you to request further details.

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| --- | --- | --- | --- |
|  | **Please answer all of the following questions.** | YES | NO |
| 1 | Have you been absent from work or education in the last two years?  If ‘Yes’, please state total number of days: |  |  |
| 2 | Have you ever left or retired from a job for medical reasons? |  |  |
| 3 | Have you ever had any illness that may have been caused by or made worse by your work? |  |  |
| 4 | Do you consider yourself to have a disability?  If ‘Yes’ and you feel that you need any adjustments or modifications to do the job for which you have applied, please give details in the box below. |  |  |
| 5 | Are you prescribed any medication, having any treatment or investigations of any kind at the moment? |  |  |
| 6 | Do you have any allergies, including latex? |  |  |
| 7 | Do you have any other medical conditions? |  |  |

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| --- |
| Please provide further details in relation to any questions that you have answered ‘Yes’ to in the box below. |
|  |

I certify to the best of my knowledge that the information on this form is true. I understand that if I should withhold information or mis-state any details, my employment may be terminated by dismissal.

Signed:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Please put your completed form in a sealed envelope marked with your name, date of birth and the post applied for and return the envelope to ANNA SUTHERLAND, HEADTEACHER