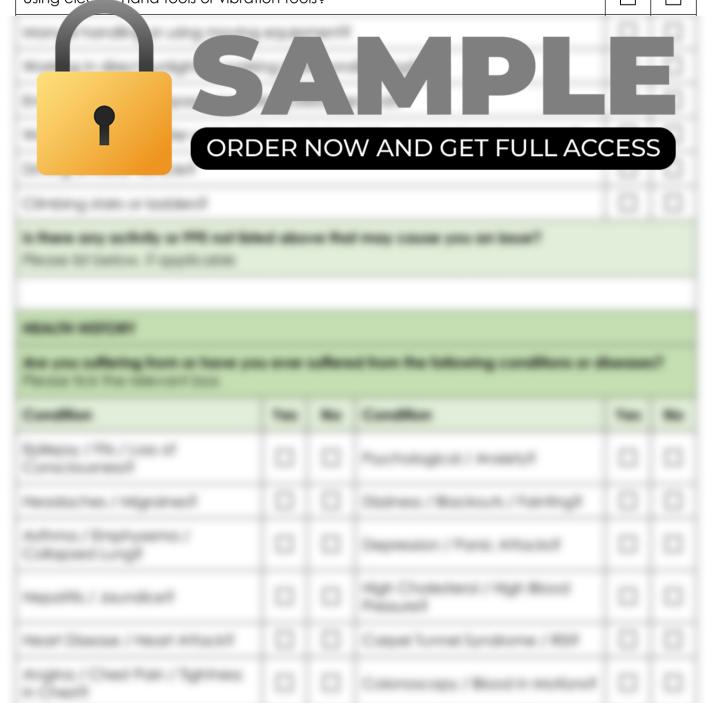
HEALTH SURVEILLANCE QUESTIONNAIRE

IT IS ACKNOWLEDGED THAT ALL INFORMATION PROVIDED ON THIS DOCUMENT WILL BE TREATED AS CONFIDENTIAL.					
Your Details					
Name:					
Address:					



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Do you suffer from any condition that would prevent (or cause an issue with) you from performing an activity or wearing PPE? Please tick the relevant box						
Activity		No				
Wearing personal protective clothing such as boots, glasses and earmuffs etc?						
Using respirators — half face, full face or breathing apparatus?						
Using electric hand tools or vibration tools?						



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Arthritis / Joint Pain?		Breathlessness / Pneumonia?		
Eczema / Psoriasis?		Dermatitis / Melanoma?		
Injuries / Sports Injury?		Back Pain / Sciatica?		
Peptic Ulcer / Gall Stones?		Irritable Bowel Syndrome / Other?		



Storage service processed

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Do you suffer from any allergies?		If yes, to what?
If yes, to you carry an Epipen?		
If yes, do you have an allergy action plan?		
		Fyds. phose correspon
		F year, placement comments



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