

Medical Questionnaire

Please complete the questionnaire below. The information is required with your interests in mind. As a result of the information you have given you may be referred to a doctor appointed by the school so that a medical examination can be carried out. If you wish, you may request an interview with the school's medical officer/nurse, either as an alternative to completing this form or to provide supplementary information or explanation.

Personal Details:

Full Name:

Date of Birth:

Position
Applied for:

Have you ever:

Please mark as appropriate

If 'Yes', please give details including Dates, continue on rear of form if necessary

1. Had an operation?	No <input type="checkbox"/> Yes <input type="checkbox"/>	
2. Been seriously injured?	No <input type="checkbox"/> Yes <input type="checkbox"/>	
3. Received in-patient treatment for a physical or mental condition?	No <input type="checkbox"/> Yes <input type="checkbox"/>	
4. Been refused or dismissed from employment for health reasons?	No <input type="checkbox"/> Yes <input type="checkbox"/>	
5. Received a disability pension?	No <input type="checkbox"/> Yes <input type="checkbox"/>	
6. Been made ill by your work?	No <input type="checkbox"/> Yes <input type="checkbox"/>	
7. Been refused a driver's licence because of ill health?	No <input type="checkbox"/> Yes <input type="checkbox"/>	

Do you suffer from or have you ever had:

	No	Yes		No	Yes		No	Yes
Diabetes	<input type="checkbox"/>	<input type="checkbox"/>	Skin rashes/eczema	<input type="checkbox"/>	<input type="checkbox"/>	Swelling of leg/Ankles	<input type="checkbox"/>	<input type="checkbox"/>
High Blood Pressure	<input type="checkbox"/>	<input type="checkbox"/>	Anaemia	<input type="checkbox"/>	<input type="checkbox"/>	Period or Prostrate Problems	<input type="checkbox"/>	<input type="checkbox"/>
Asthma	<input type="checkbox"/>	<input type="checkbox"/>	Headaches (Frequent)	<input type="checkbox"/>	<input type="checkbox"/>	Varicose Veins	<input type="checkbox"/>	<input type="checkbox"/>
Cough(Frequent)	<input type="checkbox"/>	<input type="checkbox"/>	Heart Trouble	<input type="checkbox"/>	<input type="checkbox"/>	Rupture	<input type="checkbox"/>	<input type="checkbox"/>
Rheumatic Fever	<input type="checkbox"/>	<input type="checkbox"/>	Chest Trouble	<input type="checkbox"/>	<input type="checkbox"/>	Back Trouble	<input type="checkbox"/>	<input type="checkbox"/>
Arthritis	<input type="checkbox"/>	<input type="checkbox"/>	Fainting or Dizziness	<input type="checkbox"/>	<input type="checkbox"/>	Ear Trouble	<input type="checkbox"/>	<input type="checkbox"/>
Epilepsy/Fits	<input type="checkbox"/>	<input type="checkbox"/>	Hay Fever	<input type="checkbox"/>	<input type="checkbox"/>	Eye Trouble	<input type="checkbox"/>	<input type="checkbox"/>
Shortness of Breath	<input type="checkbox"/>	<input type="checkbox"/>	Jaundice	<input type="checkbox"/>	<input type="checkbox"/>	Nerve Trouble	<input type="checkbox"/>	<input type="checkbox"/>

Do you take medicine Regularly?	<input type="checkbox"/>	<input type="checkbox"/>	Do you need glasses to read?	<input type="checkbox"/>	<input type="checkbox"/>	Have you worked in a dusty trade?	<input type="checkbox"/>	<input type="checkbox"/>
Have you ever Had a head injury?	<input type="checkbox"/>	<input type="checkbox"/>	Do you suffer from any other ailments?	<input type="checkbox"/>	<input type="checkbox"/>			

Declaration

To the best of my knowledge and belief, the information I have given above is correct. I understand that if I am appointed and this information is incorrect, I am liable to dismissal.

Your Signature

Date:

Print Name: