**CONFIDENTIAL**

**PRE TRAINING HEALTH ASSESSMENT**

**HEALTH DECLARATION QUESTIONNAIRE INFORMATION**

Thank you for accepting a place on a pre-registration healthcare course at The University of Northampton.

All applicants for pre-registration healthcare courses need to undertake occupational health screening. **You therefore need to do the following now:-**

1. Complete the **Health Declaration Questionnaire** on pages2-5.

2. Send the completed Health Declaration Questionnaire to your designated **Occupational Health Department,** which is at Kettering General Hospital.

If you have any queries or problems relating to the completion of the form please contact

the Occupational Health Department at your designated department:

**Kettering General Hospital NHS Trust 01536 492234**

If you require any other information or advice, please contact Admissions on 0300 303 2772.

**Host site addresses**

You should return your forms to your designated Occupational Health Department and mark the envelope as confidential.

Occupational Health Department

Warren Hill House

Kettering General Hospital NHS Trust

Rothwell Road

Kettering

NN16 8UZ

Alternatively, you may email your completed form to:

kgh-tr.occupational.health@nhs.net

The purpose of this health needs assessment is to assess whether you have any health condition(s) that could affect your ability to undertake your nurse training and to ensure that your health is not placed at risk within the workplace. It is also to establish whether you may require any specific adjustments in accordance with the disability provision of the Equality Act 2010.

**Please complete all sections fully in black ink/print. Incomplete health questionnaire may delay health clearance.**

|  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| Training course: | | | | | | | | Commencement date: | | | | | |
| Surname: | | | Forename: | | | | | National Insurance no: | | | | | |
| Maiden/Previous Name (if applicable): | | | | | | | | | | | | | |
| Date of Birth: | Place and Country of Birth: | | | | | | | | Male: | | | Female | |
| Address: (This should be your current address. Please inform the OH Department whenever this changes) | | | | | | | GP’s Name and Practice Address: | | | | | | |
| Post Code: | | | | | | | Post Code: | | | | | | |
| Home Telephone: | | | | | | | NHS Number : | | | | | | |
| Mobile Telephone: | | | | | | | | GP Telephone: | | | | | |
| NHS number if known: | | | | | | | | Personal e-mail: | | | | | |
| **Have you previously worked for Kettering General Hospital NHS Foundation Trust?**  **If YES, please supply details below** | | | | | | | | | | | YES | | NO |
| Your Name (if different to now): | Job Role | | | | Department | | | | | Start and finish dates | | | |
|  | | | | | | | | | | | | | |
| **DETAILS OF PREVIOUS EMPLOYMENT.** Please continue on a separate sheet if necessary | | | | | | | | | | | | | |
| Employer’s Name | | Job Role | | | | Start and finish dates | | | | | | | |
| 1. | |  | | | |  | | | | | | | |
| 2. | |  | | | |  | | | | | | | |
| **SICKNESS ABSENCE –** Please indicate time lost from work or education in the last **2 years** due to illness. Please put Zero if none. Do not leave this section blank. Please continue on a separate sheet if necessary | | | | | | | | | | | | | |
| Dates and length of absence | | | | Reason for absence | | | | | | | | | |
|  | | | |  | | | | | | | | | |
|  | | | |  | | | | | | | | | |

|  |  |  |  |
| --- | --- | --- | --- |
| **Please answer all the questions below as fully as possible. If you tick YES, please provide further details i.e. Name of condition, date diagnosed, current treatments, ongoing problems and how you feel this would affect your ability to do your work. Please continue on a separate sheet if necessary.** | **Yes** | **No** | **Further Information** |
| 1. Do you have any health condition/impairment/disability (physical or mental) which may affect your ability to do your work? |  |  |  |
| 2. Have you ever had any illness/impairment/disability which may have been caused or made worse by your work? |  |  |  |
| 3. Are you having, waiting for treatment, undergoing investigations or taking medication at present? If your answer is yes, please provide further details |  |  |  |
| 4. Do you think you may need any adjustments or assistance to help you to do the role you have applied for? |  |  |  |

|  |  |  |  |
| --- | --- | --- | --- |
| **Tuberculosis (TB) Screening** | Yes | No | If you have answered Yes to any of the questions please give details below |
| Have you, or any close friend or relative, had TB or been in recent contact with open TB? |  |  |  |
| Have you ever lived or worked abroad?  If Yes, please list all the countries that you have  lived or worked in, the dates and the length of your stay |  |  |  |
| Do you have any condition or received/receiving treatment that could impair your immune system e.g. HIV, long term steroid treatment, chemotherapy |  |  |  |
| **Do you have any of the following symptoms?** | Yes | No |  |
| A persistent cough |  |  |  |
| Unexplained weight loss |  |  |  |
| Unexplained fever with/without night sweats |  |  |  |
| Have you ever had a Heaf or Mantoux test?  If Yes, please state the date of the test and the result. |  |  |  |
| Have you had a BCG vaccination to protect you against Tuberculosis? If Yes, please give date of vaccination |  |  |  |
| Have you had a chest X-ray in the last 12 months?  If Yes, when did you have it and what was the result |  |  |  |

|  |  |  |  |
| --- | --- | --- | --- |
| **Skin conditions** | Yes | No | If you have answered Yes to any of the questions please give details below: |
| Do you have any skin conditions e.g. eczema, psoriasis, allergic or contact dermatitis especially if it affects your hands. |  |  |  |
| Do you have an allergy to Latex? |  |  |  |

|  |  |  |  |
| --- | --- | --- | --- |
| **This section should be completed by prospective students who will be undertaking Exposure Prone Procedures (EPP)\* - *see definition below*** | Yes | No | If Yes, please state the date and result\*\*: |
| Will you be performing exposure prone procedures (EPP)? |  |  |  |
| Have you ever been tested for **HIV/AIDS**? |  |  |  |
| Have you ever been tested for **Hepatitis B**? |  |  |  |
| Have you ever been tested for **Hepatitis C**? |  |  |  |

The information supplied in this form is **confidential** to the Occupational Health Teams and will not be disclosed to any other person(s) without your written consent. Kettering General Hospital NHS Foundation Trust is an equal opportunities employer, seeking to promote equality in the workplace. They do not discriminate against those who have a disability but seek to limit the impact of the disability by fulfilling its duties as specified in the Equality Act 2010. The Occupational Health Services may contact you or offer you an appointment to be seen if this is considered necessary and may recommend adjustments where appropriate.

The decision about whether it would be reasonable to accommodate a particular adjustment is the responsibility of the University of Northampton taking into account their legal obligation.

\***Exposure Prone Procedures (EPP**) are those procedures where the worker’s gloved hands may be in contact with sharp instruments, needle tips or sharp tissue (e.g. spicules of bone or teeth) inside a patient’s open body cavity, wound or confined anatomical space where the hands or fingertips may not be completely visible at all times. Examples of EPP staff include all surgeons, midwives, A&E staff, theatre staff and some dental staff. If you are not sure if your role will involve EPP work please contact the Occupational Health Department.

**\*\*If you have previous blood results and / or documented evidence confirming your HIV, Hepatitis B and Hepatitis C status, please supply copies with this form. Please note that for these to be accepted, they must be from an identified validated sample (IVS).** An Identified Validated Sample is one taken in a UK NHS Occupational Health Department from the health care worker whose identity is confirmed at the time by photographic evidence (passport, driving licence etc).If results are not available you will be tested in this department and health clearance for EPP work will be delayed until the results are processed.

**Vaccinations/blood test results**

Please include copies of official documentation of all vaccinations that you have received and blood test results carried out to confirm immunity. The records can usually be obtained from your General Practitioner (GP) and/or your Occupational Health Department if previously employed in a health care setting. This may reduce the need for you to have further injections and blood-tests.

**Declaration by Applicant**

I confirm that the information given on this form is true and complete. I understand that if any information is false or has been deliberately omitted, I may be regarded as ineligible for employment or liable to be dismissed. I understand that medical details will not be divulged without my permission to any person outside the Occupational Health Service but an opinion about my fitness to work and advice on adjustments, if required, will be given to management. I agree to an Occupational Health record being kept recording my health while at work.

|  |  |
| --- | --- |
| **Signature:** | |
| **Print name:** | **Date:** |

|  |  |
| --- | --- |
| **Before submitting the completed questionnaire, please ensure you complete the check box below:** | **Yes** |
| I have completed all the relevant sections of the form fully. |  |
| I have attached copies of relevant blood tests and immunisations as requested in this form |  |
| I have completed the declaration above, signed and/or printed my name and dated the form |  |