**FOOD HANDLERS QUESTIONNAIRE**

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| Title i.e. Prof/ Dr/ Mr/ Mrs/ Miss/ Other: |  | | | |
| Surname: |  | | | |
| First Name/ s: |  | | | |
| Address & Post Code: |  | | | |
| Date of Birth: |  | | | |
| Job Title: |  | | | |
| Department Name and Address: |  | | | |
| Contact Telephone Number: |  | | | |
| Date Commenced Post: |  | | | |
| **Do you currently suffer from or have you ever in the past suffered from any of the following:-** | | | **YES** | **NO** |
| Skin problems affecting your hand, arms, head or face? | | |  |  |
| Weeping, discharge, lesions, ulcers with your skin, ears, eyes or mouth? | | |  |  |
| Recurrent chest infections? | | |  |  |
| Allergies of any kind e.g. latex, nickel? | | |  |  |
| Diarrhoea and/ or vomiting now or in the past several days? | | |  |  |
| Bowel disorders? | | |  |  |
| Campylobacter, bacillus cereus, clostridium, cholera, dysentery, e-coli, salmonella, viral gastroenteritis, rotavirus, worms, hepatitis A (please circle if appropriate)? | | |  |  |
| Have you ever been a carrier of typhoid or paratyphoid? | | |  |  |
| Have you ever been in contact with a person who is a known carrier of typhoid or paratyphoid? | | |  |  |
| If **‘YES’** to any of the above, please use this space to provide further details:- | | | | |
| How long did the symptoms last? | |  | | |
| Did you visit your General Practitioner or other? | |  | | |
| Have you taken any medication? | |  | | |
| Any other information that you may think is relevant. | |  | | |

The information supplied by you on this questionnaire will be used to produce a certificate. This will be forwarded to your line manager/supervisor as evidence of your fitness to work/study.

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| **Name** | **Signature** | **Date** |
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