The University of Manchester

Occupational Health Service
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# CONFIDENTIAL
# HEALTH DECLARATION QUESTIONNAIRE
# FIELD TRIP/ STUDY/ WORK ABROAD

1. To participate in a School field trip, work abroad as a language assistant, or study abroad, a registered doctor must complete and sign the form provided by your School, or issue a certificate that confirms your fitness to travel.
2. In the majority of cases the information provided by you in this, your "Health Declaration", will be sufficient, when signed by Occupational Health, to pass you as medically suitable for your field trip/ travel/ study. Some students however may be required to discuss information contained in their Health Declaration in further detail with a Occupational Health Nurse/ Doctor and may subsequently require a medical examination.
3. The Occupational Health Services will contact you and offer an appointment to see the Occupational Health Nurse/Doctor if more information is required.
4. Additionally Occupational Health Services will offer appointments for your travel advice and any recommended vaccinations.
5. Please note that any medical details supplied will remain confidential to Occupational Health Services and no information will be provided to others without your informed consent.

- **Vaccinations are often required when travelling overseas. It is the applicants own responsibility to check their vaccination status is fully up to date and that any necessary vaccinations needed for overseas travel have been completed prior to departure.**
- **Occupational Health Services will NOT issue you with your signed Field Trip/ Travel/ Study Abroad Certificate unless your completed Health Declaration has been screened and you attend for any recommended vaccinations.**
- **You may be excluded from the field trip if you do not possess a signed Field Trip Certificate.**

# HEALTH DECLARATION QUESTIONNAIRE

| | |
|---|---|
| **Surname:** | **Forename:** |
| **Date of Birth:** | |
| **Destination:** | |
| **Proposed date of travel:** | **Return date of travel:** |
| **Department/ School:** | **Course:** |
| **Address:** | |
| **Telephone:** | **Mobile:** |
| **Email (University:** | **Email (Other)** |

| **1.** | **Do you take regular medication** | **Yes** | **No** |
|---|---|---|---|
| | If **YES** please give details:- | | |

| **2.** | **Do you have any known allergies to medications** | **Yes** | **No** |
|---|---|---|---|
| | If **YES** Please give details:- | | |

| **3.** | **Is there any family history of illness** | **Yes** | **No** |
|---|---|---|---|
| | If **YES** Please give details:- | | |

| **4.** | **Heart and Circulation.** | | |
|---|---|---|---|
| | Have you ever suffered from a heart attack, chest pains, angina or high blood pressure | **Yes** | **No** |
| | If **YES** which condition(s) | | |
| | What treatment(s) are you receiving | | |
| | Please give details including how the condition affects you now | | |

| 5. | **Have you any known phobias** | **Yes** | **No** |
|---|---|---|---|
| | Vertigo | | |
| | Claustrophobia | | |
| | Any other, not listed above | | |
| | What treatment are you receiving | | |
| | Please include details including how the condition affects you now. | | |

| 6. | **Respiratory Problems.** Have you ever suffered from the following:- | | |
|---|---|---|---|
| | Bronchitis | **Yes** | **No** |
| | Asthma | **Yes** | **No** |
| | Shortness of breath | **Yes** | **No** |
| | A persistent cough (for more than 3 weeks) | **Yes** | **No** |
| | What treatment are you receiving | | |
| | Please include details including how the condition affects you now. | | |

| 7. | **Psychological Illness.** Have you ever suffered from the following:- | | |
|---|---|---|---|
| | Depression | **Yes** | **No** |
| | Anxiety | **Yes** | **No** |
| | Schizophrenia | **Yes** | **No** |
| | Stress | **Yes** | **No** |
| | Drug or alcohol-related problems) | **Yes** | **No** |
| | What treatment are you receiving | | |
| | Please give details including how the condition affects you now | | |

| | | | |
|---|---|---|---|
| **8.** | **Nervous System.** Have you ever suffered from any of the following | | |
| | Blackouts | **Yes** | **No** |
| | Recurrent fainting attacks | **Yes** | **No** |
| | A stroke | **Yes** | **No** |
| | Fits or epilepsy | **Yes** | **No** |
| | Muscular weakness | **Yes** | **NO** |
| | If **YES** which treatment are you receiving | | |
| | Please include details including how the condition affects you now. | | |

| | | | |
|---|---|---|---|
| **9.** | **Digestive System.** Have you ever suffered from any of the following | | |
| | Ulcer | **Yes** | **No** |
| | Colitis | **Yes** | **No** |
| | Ileostomy | **Yes** | **No** |
| | Colostomy | **Yes** | **No** |
| | Irritable bowel syndrome (IBS) | **Yes** | **No** |
| | What treatment are you receiving | | |
| | Please include details including how the condition affects you now. | | |

| | | | |
|---|---|---|---|
| **10.** | **Genito Urinary System.** Have you ever suffered from | | |
| | Kidney problems | **Yes** | **No** |
| | Bladder problems | **Yes** | **No** |
| | Reproductive tract problems | **Yes** | **No** |
| | What treatment are you receiving | | |
| | Please include details, including how the condition affects you now. | | |

| | | | |
|---|---|---|---|
| **11.** | **Musculoskeletal System.** | | |
| | Have you ever suffered from back or neck trouble, rheumatism, arthritis or other joint/ muscle problems | **Yes** | **No** |
| | If **YES** which condition | | |
| | What treatment are you receiving | | |
| | Please include details, including how the condition affects you now. | | |

| | | | |
|---|---|---|---|
| **12.** | **Skin.** | | |
| | Do you suffer from eczema, dermatitis, psoriasis or any other skin condition | **Yes** | **No** |
| | If **YES** which condition | | |
| | What treatment are you receiving | | |
| | Please include details, including how the condition affects you now | | |

| | | | |
|---|---|---|---|
| **13.** | **Are you able to perform reasonable strenuous exercise?** | **Yes** | **No** |

| | | | |
|---|---|---|---|
| **14.** | **Are you, to the best of your knowledge, in good health at present?** | **Yes** | **No** |

| | | | |
|---|---|---|---|
| **15.** | **Have you ever suffered from any other medical conditions requiring treatment/ hospital admission/ surgery within the last 6 months?** | **Yes** | **No** |
| | If **YES** please provide details: | | |

| | | | |
|---|---|---|---|
| **16.** | Do you have any religious or other constraints on medical treatment? | **Yes** | **NO** |
| | If **YES** please provide details: | | |

***I declare the information above to be, to the best of my knowledge, true and accurate. However, if, between now and my due date of departing, my medical circumstances should change I undertake to seek further medical advice regarding my suitability to travel.***

The information supplied by you on this questionnaire will be used to produce a certificate. This will be forwarded to your Line Manager / Supervisor or School Administrator as evidence of your fitness to travel

| | | |
|---|---|---|
| **Name:** | **Signature:** | **Date:** |

# VACCINATION HISTORY

Please give details of your vaccinations against the following diseases. This is particularly important if your course/ field trip exposes you to biological hazards or if you are undertaking a health or science based course. These details may be available from your General Practitioners medical records or Child Health Records. Please request this information from your General Practitioner.

| | **Dates of Doses:** | | | | |
|---|---|---|---|---|---|
| | **First** | **Second** | **Third** | **Fourth** | **Fifth** |
| **Polio** | | | | | |
| **Tetanus** | | | | | |
| **Diphtheria** | | | | | |
| **BCG/Mantoux (TB vaccination**) | | | | | |
| **Hepatitis A** | | | | | |
| **Hepatitis B** | | | | | |
| **Combined Hepatitis A & Hepatitis B** | | | | | |
| **Hepatitis B Anti HBs** | **Antibody Level:** | | | **Date:** | |
| **Typhoid** | | | | | |
| **Combined Hepatitis A & Typhoid** | | | | | |
| **Meningitis C** | | | | | |
| **Meningitis ACWY** | | | | | |
| **Japanese Encephalitis** | | | | | |
| **Rabies** | | | | | |
| **Yellow Fever** | | | | | |
| **Cholera** | | | | | |
| **MMR** | | | | | |
| **Other** | | | | | |

| Name: | Signature: | Date: |
|---|---|---|