

Galtres Care Home

Health Assessment Questionnaire

The purpose of this questionnaire is to assess your fitness as care workers.
 This is part of our duties under the **CARE STANDARDS ACT 2000**
 (Regulation 7,9,19).
 It is also to comply with the **WORKING TIME REGULATIONS 1998**.

To be completed by employee:		
Date		
Name		
Job Title		
Date Employment Began		
Do you suffer from any of the following conditions		Please circle the appropriate answer
Diabetes requiring injections to a strict timetable	Yes	No
A heart or circulatory disorder which affects your physical stamina	Yes	No
Stomach or intestinal disorder, such as ulcers	Yes	No
Any other condition which makes the timing of meals of particular importance	Yes	No
A medical condition affecting sleep	Yes	No
A chronic chest condition	Yes	No
Any medical condition requiring medication on a strict timetable	Yes	No
Any other medical condition in which the symptoms get worse at night	Yes	No
Do you suffer from any other medical conditions that may affect your ability to perform your job in a safe manner	Yes	No
Where you have answered yes, please give further details		
<i>(continue on a separate sheet if necessary)</i>		
I declare that I am physically and mentally fit for the purposes of the work which is to be performed		
Signature of person making this statement		
Date of statement		
For Office Use only		
This person has been deemed physically and mentally fit to carry out care worker duties following reference checks, health assessment and satisfactory C.R.B. checks		
Signed Position.....		
Name		
Date		