# Health Declaration Form

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| **Name (full):** |  |
| **Address:** |  |
|  |  |
|  |  |
| **Telephone:** |  |
| **Email:** |  |

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|  | Do you have any health condition that affects you in the following ways or any of the conditions listed below? If ‘yes’, please give full details. |
|  | **Condition** | **Yes** | **No** | **Treatment (in the last five years, current or planned in the future)** |
|  | Any condition that affects your physical ability to walk, balance, bend, kneel or lift a child or young person. |[ ] [ ]        |
|  | Any condition that might make you become confused or disorientated. |[ ]  [ ]  |       |
|  | Any condition that affects your hearing in any way (after correction with a hearing device). |[ ]  [ ]  |       |
|  | Any condition that affects your eyesight in any way (after any lens correction). |[ ]  [ ]  |       |
|  | Depression, stress-related or emotional issues, or any other condition that causes anxiety, panic attacks, mood swings or anger. |[ ]  [ ]  |       |
|  | Any condition that causes severe pain. |[ ]  [ ]  |       |
|  | Any condition that causes excessive drowsiness. |[ ]  [ ]  |       |
|  | Epilepsy or any other condition that causes blackouts, fits or fainting. |[ ]  [ ]  |       |
|  | Any heart problems. |[ ]  [ ]  |       |
|  | Diabetes. |[ ]  [ ]  |       |
|  | Asthma or any other breathing difficulties.  |[ ]  [ ]  |       |
|  | Any alcohol or drug dependency or misuse. |[ ]  [ ]  |       |
|  | Any significant infectious diseases such as tuberculosis or hepatitis, which may pose a risk if not treated. |[ ]  [ ]  |       |
|  | Any mental health disorder. |[ ]  [ ]  |       |

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|  | Are you taking any medication which may affect your suitability to care for children?If ‘yes’, please complete this section below. | Yes | No |
|  |  | [ ]  | [ ]  |
|  | Medication name |  Reason for medication | Dosage | How long you’ve been taking medication |
|  |       |   |       |       |
|  |       |       |       |       |
|  |       |       |       |       |
|  |       |       |       |       |
|  |  |  |  |  |
|  | In the past five years, have you:* had any other medical problems or degenerative conditions that may affect your suitability to care for children
* been admitted to hospital or had outpatient treatment for any other reason?

We use this information to help us understand any medical conditions that may affect your suitability to care for children. You do not have to tell us about any minor illnesses that you have not needed medical treatment for, such as flu.If ‘yes’ to either of the above, please give details. | Yes | No |
|  |  |[ ] [ ]
|  |  |[ ] [ ]
|  | Date | Details |
|  |   |   |   |   |   |   |   |   |        |
|  |   |   |   |   |   |   |   |   |        |
|  |   |   |   |   |   |   |   |   |       |
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|  | If you answer ‘yes’ to any of these, please give full details. | Yes | No |
|  | Do you have a driving licence? |[ ] [ ]
|  | Have you ever had restrictions put on your licence or had difficulty getting insurance because of health problems? |[ ] [ ]
|  | Have you ever had your insurance refused on health grounds?  |[ ] [ ]
|  | Do you smoke? |[ ] [ ]

|  |  |
| --- | --- |
|  | **Name:** |
| **SIGN** |  |  |  |
|  | **Date:** |  |  |