

Occupational Health Service Confidential Health Questionnaire for Dental Academy Staff & Students

GUIDANCE FOR COMPLETION OF HEALTH QUESTIONNAIRE

The University is obliged to ensure that staff are able to work safely in a clinical environment and for students to have good health to manage the rigours of the course, to study and to work safely in a clinical environment and maintain professional standards of conduct and behaviour.

See: <https://www.gdc-uk.org/about-us/what-we-do/fitness-to-practise>

https://heops.org.uk/wp-content/uploads/bsk-pdf-manager/2019/09/1521730860HEOPS_Dental_Students_fitness_standards_2013_v11.pdf

Poor health may put patients, service users and/or colleagues at risk by transfer of infection or because of ill-judgment or impaired performance. All staff and students are therefore asked to complete an initial health screening procedure using this confidential health questionnaire. As a member of staff or student at the Dental Academy you are likely to be exposed to a number of infectious diseases in your practice and or when on placement. Information about your immunity status to common infectious diseases and vaccination record is requested so please ensure you include this information on the attached form if you are going to be undertaking clinical Practice / Placement. **Please attach your vaccination record, which you should be able to obtain from your GP or previous Occupational Health Department.**

You should provide as much detail as possible about any ongoing health concerns which will enable the Occupational Health Practitioners to assess your fitness and to make any recommendations to support you in your work / studies.

You should complete all sections of the form. Having a health condition, an illness or impairment will not prevent a staff / student from work or entering placement, provided that adjustments or modifications can enable them to achieve the necessary competencies of knowledge, skills and behaviour required for their role / course. You are therefore actively encouraged to disclose such information.

You are obliged to make the University's Occupational Health Service aware of any changes to your health between completing this health questionnaire and starting your course so that we can consider any necessary adjustments for you.

The Occupational Health Practitioner will screen health questionnaires and we may contact you to arrange an occupational health consultation or conduct a follow up via telephone / email, arrange medicals or with your consent obtain medical reports as appropriate from e.g. your GP / Hospital Specialist. You will receive a letter of notice to inform you of when we are writing to obtain a medical report if deemed necessary.

The Occupational Health Practitioner will advise the University (and or the Science Faculty Placement Office and relevant Department) regarding your fitness for role / course. Personal or sensitive information will not be disclosed to third parties without your express consent unless it is deemed in the public interest. No details of any medical conditions will be forwarded to the University without your specific consent.

The fully completed health questionnaire form with the self-declaration signed and dated must be sent to Occupational Health via email as follows:

For all Staff roles send via email to occupationalhealth@port.ac.uk.

All Students must send via email to ohda@port.ac.uk.

**Occupational Health Service
Confidential Health Questionnaire for Dental Academy Staff & Students**

HEALTH QUESTIONNAIRE

Your answers to this questionnaire will be confidential to the occupational health team and will not be given to anyone else without your permission. The purpose of the questionnaire is to see whether you have any health problems that could affect your ability to undertake your role / your chosen course or place you at any risk in the workplace in practice or during placements.

Staff / Student details							
Title:	<input type="checkbox"/> Mr	<input type="checkbox"/> Mrs	<input type="checkbox"/> Miss	<input type="checkbox"/> Ms	<input type="checkbox"/> Dr	<input type="checkbox"/> Prof	Other:
Male: <input type="checkbox"/>				Female: <input type="checkbox"/>			
Surname:				Forename(s):			
Previous names (if applicable):							
Date of birth:							
Home Address:							
Local Address (in Portsmouth if known)							
Contact number/s:	Work ext:	Mobile:			Home:		
Email							
Employment / Course details <i>(tick and complete as appropriate)</i>							
Department:							
STAFF <input type="checkbox"/>				STUDENT <input type="checkbox"/>			
Job title:				Name of Course:			
Start date:				Start Date:			

Please answer all of the following questions.

Occupational Health Service

Confidential Health Questionnaire for Dental Academy Staff & Students

If you answer yes to any questions, please give as much detail as possible, continuing on a separate sheet of paper if necessary.

If printed, please use BLACK pen and complete in block capitals.

Questions	Yes	No	Details and dates If 'Yes' please specify which condition or problem and any treatment received
1. Do you have or have you ever had any illness/impairment/disability (physical or psychological) which may affect your role / course (including ability to undertake practice / placements)?			
2. Have you ever had any illness/impairment/disability which may have been caused or made worse by your study/work?			
3. Are you having, or waiting for treatment (including medicine, pills, injections or inhalers) or investigations at present?			
4. Do you think you may need any adjustments or assistance to help you on your role / course or to undertake practice / placements?			
5. Do you have any hearing problems?			
6. Do you have any problem with speech or communication? Including use of the telephone?			
7. Do you have any visual problems?			
8. Have you ever had a back problem?			
9. Do you have any difficulties standing, bending, lifting or with any other movements?			
10. Have you ever had any problems with your joints including pain, swelling or stiffness?			
11. Have you ever suffered from any mental illness, psychological or psychiatric problem, including depression, anxiety, bi-polar, nervous debility, nervous breakdown, schizophrenia or eating disorder?			
12. Have you ever received any treatment for a drug or alcohol problem?			
13. Have you ever had any skin problems?			
14. Have you ever had fits, blackouts or epilepsy?			
15. Do you suffer from migraines or recurrent headaches?			
16. Do you have any other medical conditions?			
17. Do you feel well at present?			
18. Are you allergic to anything? If so what? Do you carry an Adrenaline Auto-Injector i.e. EpiPen?			
19. If 'yes', have you ever been treated in hospital? Please give reason(s) and date(s).			
20. Have you or a close family member (within the last 5 years) ever had treatment for Tuberculosis (TB)?			
21. In the last 12 months, have you had a cough for more than 3 weeks, coughed up blood or had any unexplained loss of weight or fever?			
22. Have you come directly from, recently worked in, visited frequently, or for an extended period (more than 3 weeks) a country of high TB incidence e.g. in Africa, SE Asia, The			



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Americas, Eastern Europe or Western Pacific?			
23. Please state your country of birth:			
24. Are you a carrier, or suspect that you may be a carrier, of any blood borne virus e.g. hepatitis B, hepatitis C or HIV (state which virus)?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Please give details:

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LATEX ALLERGY

Latex products are widely used in health care. In order to identify individuals who may be prone to latex sensitisation and reduce any risks to their health please complete the following latex allergy screening questions:

25. Have you been diagnosed as suffering from a latex (natural rubber) allergy?	
If yes, please give details:	Yes <input type="checkbox"/> No <input type="checkbox"/>
26. Have you ever had a reaction following contact with products containing latex?	
If yes, please give details:	Yes <input type="checkbox"/> No <input type="checkbox"/>
27. Have you ever had a reaction after eating the following foods: Banana, Avocado, Kiwi, Chestnut, Potato, Mango, Tomato?	
If yes, please give details:	Yes <input type="checkbox"/> No <input type="checkbox"/>
28. Do you have a history of contact dermatitis when wearing gloves?	
If yes, please give details:	Yes <input type="checkbox"/> No <input type="checkbox"/>
29. Have you ever had a severe allergic reaction in the presence of latex (e.g. wheezing, facial swelling, collapse)?	
If yes, please give details:	Yes <input type="checkbox"/> No <input type="checkbox"/>

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May we have your consent to communicate with / request information from your General Practitioner, and if necessary from other Medical Practitioner / Hospital Specialist for further information? The information will be used to assess fitness for the role / course for which you're commencing.

Signed:

Date:

SELF- DECLARATION

(Please read carefully and ensure you tick the appropriate parts)

I declare that the answers to the above questions are true and complete to the best of my knowledge and belief.

I declare that all of the statements and information I have made on this questionnaire are true to the best of my knowledge. I understand that giving false information or failing to disclose any significant information could result in an offer or role or training place being withdrawn.

I am not aware of any medical reason that would prevent me from carrying out the duties required of me during my studies and placements.

I understand that if I develop any allergic reaction that could relate to the above products during my course I shall notify my personal tutor and seek advice from Occupational Health

I agree to attend an occupational health assessment, if necessary.

I understand that if any recommendations to the University of Portsmouth Dental Academy Clinical Director and/or Science Faculty Placements Manager are necessary as a result of this health questionnaire, the Occupational Health Service will discuss the recommendations with me before making them.

I give / I do not give

consent for the Occupational Health Service to make recommendations to the University of Portsmouth Dental Academy Clinical Director and / or the Science Faculty Placement Manager without me having seen a written copy of the recommendations first.

Signed _____

Date _____

**PLEASE COMPLETE & SIGN HEALTH QUESTIONNAIRE & CONSENT FORM
RETURN ALL PAGES INCLUDING THE IMMUNISATION RECORD, AS
ATTACHMENTS VIA EMAIL TO ohda@port.ac.uk
PLEASE DO NOT SHARE IT VIA GOOGLE DRIVE**

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FORM OF CONSENT FOR GP / SPECIALIST MEDICAL REPORT

APPLICANT DETAILS

Name: Telephone No:

Address: Date of Birth:

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YOUR AUTHORISATION

I hereby consent to a medical report being supplied in confidence to the Occupational Health Nurse/Physician at the University of Portsmouth. I understand that the clinical details within the medical report received will not be disclosed to the University, but advice based on them might be given to the University.

(Please ensure that the appropriate parts are ticked)

I understand that I shall be contacted at the time when this information has been requested and that under the Access to Medical Reports Act, 1988:

- I have the right to see the report before it is sent.
- I am entitled to ask the doctor to amend or modify information which I consider is inaccurate.
- I have 21 days from notification to seek access to the report.

I wish to seek access to this report before it is sent to Occupational Health

I do not wish

My family doctor is:

My Specialist is:

<p>Name:</p> <p>Address:</p> <p>Postcode:</p> <p>Telephone Number:</p>	<p>Name:</p> <p>Address:</p> <p>Postcode:</p> <p>Telephone Number:</p>
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Signed _____

Date _____

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FOR STAFF & STUDENT UNDERTAKING CLINICAL PRACTICE / PLACEMENTS

IMMUNISATION RECORD

Please complete the table below and attach evidence of vaccination records and serology reports for the vaccinations detailed below. For Exposure Prone Procedure (EPP) students, proof of negative hepatitis B surface antigen, negative HIV and hepatitis C status is required; these will be completed as part of their Occupational Health assessment on commencement of their course.

Immunisation	Dates	Antibody result (if known/ applicable)
Tetanus		
Polio		
Diphtheria		
BCG (TB vaccination)		
Tuberculin Skin Test (Mantoux/Heaf)		
MMR 1		
MMR 2		
Varicella Immunity or positive history of chickenpox		
Meningitis C (recommended for University students)		
Hepatitis B injection 1		
Hepatitis B injection 2		
Hepatitis B injection 3		
Hepatitis B Antibody Test (Identity Validated Sample)		
Hepatitis B injection 5 year booster		
Hepatitis B Surface Antigen (Identity Validated Sample required)		
HIV (Identity Validated Sample required)		
Hepatitis C antibody (Identity Validated Sample required)		