# University logoOff-site work health declaration

**CONFIDENTIAL**

## Fieldwork disability and health declaration

The University of Bristol Faculty/School of (...........) has a duty of care towards staff and students whilst carrying out work activities off-site. In the interests of your health and safety and other participants on the fieldwork you are asked to complete a health declaration form. The questionnaire asks participants to disclose specified medical conditions and to provide information on any disability/health condition that may require support during fieldwork.

You must read all associated risk assessments and safety documentation so that you fully understand the risks associated with the activities you will be undertaking before completing this declaration.

This information will be shared with the Fieldwork Leader and passed to the University Occupational Health Service for a more detailed assessment if necessary. Whilst disclosure of any disability or medical condition is not compulsory, you are strongly recommended todisclose any disability or health condition that could impact on your ability to participate in the fieldwork or that may need specific treatment if you become ill. This information will not be disclosed to anyone else on the course without your permission, unless an emergency makes it necessary to do so.

Following the fieldwork the form will be destroyed.

If you have any queries please contact (.......................................).

Guidance is available from Disability Services at: <http://www.bristol.ac.uk/disability-services/>

Or the University Occupational Health Service details at: <http://www.bristol.ac.uk/safety/health/>

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## Fieldwork disability and health declaration form

The information provided will be treated as confidential and seen only by the fieldwork leader and if necessary the University of Bristol Occupational Health Service.

**Section 1: Personal details**

| Title (Mr,Ms,Mrs,Miss,etc) |  |
| --- | --- |
| Family name |  |
| Given name(s) |  |
| Contact address |  |
| Postcode |  |
| Home telephone number |  |
| Mobile number |  |
| E-mail address |  |
| Date of birth |  |
| Male / Female |  |
| General practitioner (Name/address and telephone number) |  |

**Section 2: Course Details**

|  |  |
| --- | --- |
| Programme of study |  |
| Fieldwork course name |  |

**Section 3: Disability**

| **Do you have a disability?** | **Yes / No / Prefer not to say** If ‘yes’, please state the nature of your disability |
| --- | --- |
| 1. Autistic Spectrum Disorder / Asperger Syndrome
 |  |
| 1. Deaf / hearing impairment
 |  |
| 1. Blind / partially sighted
 |  |
| 1. Learning difficulty
 |   |
| 1. Mental health difficulty
 |  |
| 1. Multiple disabilities
 |  |
| 1. Dyspraxia
 |  |
| 1. Unseen disability e.g. diabetes, epilepsy
 |  |
| 1. Wheelchair user / Mobility difficulty
 |  |
| 1. Other disability
 |  |

**Section 4: Your functional capabilities**

|  |  |  |
| --- | --- | --- |
| **Do any of the following present you with difficulty?** | **Yes** | **No** |
| 1. Mobility e.g. walking, running, using stairs
 |  |  |
| 1. Agility e.g., bending, reaching up, kneeling down, maintaining balance
 |  |  |
| 1. Physical exertion e.g. lifting, carrying, running
 |  |  |
| 1. Communication e.g. speech, hearing
 |  |  |
| 1. Vision e.g. visual impairment, colour blindness, tunnel vision
 |  |  |
| If you answered yes, please give further details if necessary: |

**Section 5: Your health**

Please answer all of the following questions. If you answer yes, please give further details, continuing on a separate piece of paper if necessary.

|  |  |  |
| --- | --- | --- |
| **1. Do you have or ever been affected by any of the following?** | **Yes** | **No** |
| 1. Chronic skin conditions? e.g. eczema, psoriasis
 |  |  |
| 1. Neurological disorder? e.g. epilepsy, fits or blackouts, multiple sclerosis
 |  |  |
| 1. Allergies? e.g. to latex, medicines, foods, animals, food
 |  |  |
| 1. Endocrine disease? e.g. diabetes
 |  |  |
| 1. Respiratory disease? e.g. asthma
 |  |  |
| 1. Sudden loss of consciousness? e.g. a fit or seizure
 |  |  |
| Please give further details if necessary |

|  |  |  |
| --- | --- | --- |
| **2. Are you currently taking any regular medication or receiving any treatment?** | **Yes** | **No** |
| If yes, give details  |

**Section 5: Declaration**

I declare that the answers to the above questions are true and complete to the best of my knowledge and belief. I understand that I may be contacted by a member of the Occupational Health Service for a more detailed assessment.

**Signed: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_** **Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**For University fieldwork leader use only**

Comments and actions:

Signed:

Date: