|  |  |
| --- | --- |
| **Name:** |  |
| **Job Role (for employees and new starters):** |  | **New Starter** | **Return to Work** |
| **Company (for visitors and contractors only):** |  |

|  |  |  |
| --- | --- | --- |
| **At present, or in the last seven days, are you suffering from (tick where appropriate):** | **Yes** | **No** |
| Diarrhoea and/or vomiting?  |  |  |
| Stomach pain, nausea, or fever? |  |  |
| Cold or Flu Symptoms including a high temperature, shortness of breath, difficulty breathing, malaise? |  |  |
| A high temperature, a new/continuous cough (coughing a lot for more than an hour), a loss or change to you sense of smell or taste? |  |  |
| **At present, are you suffering from:** |
| Skin infections or open wounds on the hands, arms, or face, e.g., cuts, lacerations, boils, sties, septic fingers, discharge from eye / ear / gums / mouth? |  |  |
| Jaundice? |  |  |
| **Do you suffer from:** |
| A recurring bowel disorder? |  |  |
| Recurring infections of the skin, ear, or throat? |  |  |
| Have you ever had Typhoid or Paratyphoid fever or are you now known to be a carrier of Salmonella Typhi or Paratyphi? |  |  |
| Are you a carrier of any type of Salmonella? |  |  |
| **Have you been in contact with:** |
| In the last 21 days have you had contact with anyone, at home or abroad, who may have been suffering from typhoid or paratyphoid? |  |  |
| Have been alerted through track and trace or have knowingly been in contact with someone who has tested positive for COVID-19. |  |  |
| **Countries visited in the last 6 weeks – please list:** |  |
| **Do you have any Allergies or Intolerances? – please list:** |  |
| **Do you have a medical need to keep medication with you whilst in product areas?** |  |
| I confirm the above is a true declaration of by current health status, and that I have read and understand the Visitor Hygiene Rules required whilst on site. | **Sign:** |  |

Any ‘YES’ answers will require an assessment of suitability to work / enter food production areas.

**For office use only**

|  |  |
| --- | --- |
| **Date:**  |  |
| **Review comments:** |
|  |
| **Manager sign off:** |  |

## **Document Control**

|  |  |
| --- | --- |
| **Document name:** | **Health screening questionnaire** |
| **Document reference:** | **CPU.FS.F.018.01** |
| **Date of 1st Issue:** | **19 August 2024** |
| **Author:** | **Food Safety** |
| **Version number:** | **1** |

|  |
| --- |
| **Revision record** |
| **Issued date of revision** | **Version** | **Details of revision** |
|  |  |  |
|  |  |  |
|  |  |  |
|  |  |  |
|  |  |  |