Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Position: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

1. Have you been diagnosed with any diseases the past six months?

Yes No If yes, when

1. Have you lived in the same household with a person diagnosed with a disease the past six months?

Yes No If yes, when

1. Have you been exposed to a confirmed disease outbreak, at work or at an event such as a family meal or social event:

Yes No If yes, when

1. Have you lived in the same household with a person who was exposed to, at work or socially where there was a confirmed disease outbreak the past six months?

Yes No If yes, when

1. Has a member of your household ever been diagnosed or exposed to jaundice?

Yes No If yes, when

1. Are you currently suffering for any of the following?

Yes No If yes, when

* 1. Diarrhoea
	2. Fever
	3. Vomiting
	4. Jaundice
	5. Sore throat with fever
	6. Any lesions containing pus
1. My Doctor (or last doctor visited) is:

# Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

1. **I AGREE TO IMMEDIATELY REPORT TO MY SUPERVISOR OR PERSON IN CHARGE:**

future symptoms of:

* 1. Diarrhoea
	2. Fever
	3. Vomiting
	4. Jaundice
	5. Sore throat with fever
	6. Any lesions containing pus
1. I have read (or had explained to me) and understand the requirements concerning my responsibility under this agreement to comply with and understand that failure, by me to complete truthfully, sign and return and comply with the terms of this health questionnaire could result in disciplinary procedures being brought against me against me and even termination of employment.

Employee name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Employee signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Manager: Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_