**FOOD HANDLERS QUESTIONNAIRE**

|  |  |
| --- | --- |
| **Name** |       |
| **Date of Birth** |       |
| **Job Title** |       |
| **Function** |       |
| **ACC Cluster** |       |
| **Employee no.** |       |

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| Have you suffered from any of the following during the past seven days? | **Yes** | **No** |
| **1** | Diarrhoea and or vomiting | [ ]  | [ ]  |
| **2** | Stomach pain, nausea or fever | [ ]  | [ ]  |

|  |  |  |
| --- | --- | --- |
| At present are you suffering from: | **Yes** | **No** |
| **3** | Skin infections of the hands, arms or face, e.g. boils, styes, septic fingers, discharge from eye/ear/gums/mouth | [ ]  | [ ]  |
| **4** | Jaundice | [ ]  | [ ]  |

|  |  |  |
| --- | --- | --- |
| Do you suffer from: | **Yes** | **No** |
| **5** | A recurring bowel disorder | [ ]  | [ ]  |
| **6** | Recurring infections of the skin, ear or throat | [ ]  | [ ]  |
| **7** | Have you ever had typhoid or paratyphoid fever or are you now known to be a carrier of any salmonella Typhi or Paratyphi | [ ]  | [ ]  |
| **8** | Are you a carrier of any type of salmonella | [ ]  | [ ]  |
| **9** | In the last 21 days have you had contact with anyone, at home or abroad, who may have been suffering from typhoid or paratyphoid | [ ]  | [ ]  |

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| Countries visited in the last six weeks: |       |

Any **Yes** answers will require an assessment of suitability to work.

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|  |  |
| --- | --- |
| **Name** |       |
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To be completed by clinical staff

|  |  |  |  |
| --- | --- | --- | --- |
| **Checks** | **Satisfactory** | **Unsatisfactory** | **Comments** |
| Eyes and Eyelids | [ ]  | [ ]  |       |
| Ears | [ ]  | [ ]  |       |
| Nose | [ ]  | [ ]  |       |
| Teeth | [ ]  | [ ]  |       |
| Hair and Scalp | [ ]  | [ ]  |       |
| Skin | [ ]  | [ ]  |       |
| Hands | [ ]  | [ ]  |       |
| Fingernails | [ ]  | [ ]  |       |
| Personal Hygiene | [ ]  | [ ]  |       |
| Stool Specimens (if indicated) | [ ]  | [ ]  |       |

**Results**

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| Fit | [ ]  | Unfit | [ ]  | Refer to |       |
| Review Date |       |
| Reason for Review: |       |

|  |  |
| --- | --- |
| **Name of Certifying Clinician** |       |
| **Designation** |       |
| **Signature** |       |
| **Date**  |       |

