**FOOD HANDLERS QUESTIONNAIRE**

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

|  |
| --- |
|  |

|  |  |  |  |
| --- | --- | --- | --- |
| 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 |  |  |

|  |  |
| --- | --- |
| Countries visited in the last six weeks: |  |

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

**FOOD HANDLERS QUESTIONNAIRE**

|  |  |
| --- | --- |
| **Name** |  |
| **Date of Birth** |  |

|  |
| --- |
|  |

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** |  |

