**Disposable Particulate Respirator Health Screening Form**

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| --- | --- |
| Name: |  |
| Organization: |  |
| Designation: |  |
| Contact Number: |  |

Have you worn a respirator before?

 Yes  No

If yes, please describe any difficulties you had while using the respirator:

Will you be wearing eye glass or personal protective equipment with the respirator?

 Yes  No

If yes, please describe:

Is there any reason you cannot wear a tight-fitting respirator that seals directly to the skin on your face?

 Yes  No

If yes, please describe:

Have you had or do you currently have any of the following:

1. Lung disease or breathing problems including asthma  Yes  No
2. Heart trouble  Yes  No
3. High blood pressure  Yes  No
4. Diabetes  Yes  No
5. Epilespsy, fainting or seizures  Yes  No
6. Trouble tasting  Yes  No

Please explain if you have selected yes to any of the above :

Please describe in detail any food, medication, environmental or other allergies you may have:

Signing this form authorizes consent to share information with the employer via the *Report of Health Assessment for Respirator Use* form regarding clearance.

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Name of health care professional

Signature of health care professional: Signature of employee:

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

 (DD/MM/YY) (DD/MM/YY)

**Assessment of Health Care Professional:**

The worker is cleared for respirator use as assessed: Yes  No

The worker is to be referred for further medical assessment**:**  Yes  No