

Form C

## MEDICAL SCREENING FOR FOOD HANDLERS

**Part I and II of this form to be completed by the applicant:**

Part I: Personal Information		
Name	Nationality	Passport No/Identity Card No./Voter Card No.
Date of Birth/Age	Sex: M <input type="checkbox"/> F <input type="checkbox"/>	Occupation
Residential Address in Bhutan:		
Contact Number:		

### Part II: Medical History (To be declared and signed by the applicant)

	Y E S	N O	If yes, give brief details		Y E S	N O	If yes, give brief details
1. Mental illness				2. Epilepsy			
3. Asthma/COPD/other allergies				4. Tuberculosis			
5. Hypertension				6. Liver diseases			
7. Heart Disease				8. Chronic skin diseases			
9. Addiction to drugs or alcohol				10. Blackouts and fainting attacks			
11. Recurrent bowel problem				12. Physical deformities			
13. Visual problem				14. Hearing Impairment			

I declare that all the information given above is correct and true. I also understand that I may be liable for actions by the concerned authority for providing false or misleading information.

Signature of the applicant.....

Date.....

**Part III: Physical Examination:** (to be completed by a registered medical or health person only)

<b>A. General</b>		<b>Normal</b>	<b>Abnormal</b>	<b>Brief details (if Abnormal)</b>
1.	Pulse rate..... Per min			
2.	Blood pressure ...../..... mm Hg			
3.	Conjunctiva ( <i>Circle</i> ) Pallor/non-icteric/others ( <i>specify</i> )			
4.	Lymphadenopathy			
5.	Pedal oedema			
6.	Visible deformity			
<b>B. Systemic</b>				
7.	Neurological status (sensory and coordination)			
8.	Cardiovascular system			
9.	Respiratory system			
10.	Per abdomen- General Liver Spleen			
11.	Skin and nail conditions			
12.	Uro-genital conditions			
13.	Musculoskeletal systems			
<b>Investigations</b>				
12.	Visual acuity			
13.	Urine RE			
14.	Blood for hepatitis B and C			
15.	Stool RE			
16.	Blood/stool CS (where indicated)			
17.	Sputum for AFB (where indicated)			
18.	Chest X-ray (where indicated)			
<b>Part IV: Certification and declaration</b>				
<p>I certify that the person is: (<i>check only one option</i>)</p> <p><input type="checkbox"/> Fit</p> <p><input type="checkbox"/> Unfit, specify reasons .....</p> <p>.....</p>				
Name and signature of the examining medical or health person			BMHC registration No. and Address:	