University of Lethbridge

Campus Safety

RESPIRATOR USER HEALTH SCREENING QUESTIONNAIRE

EMPLOYEE INFORMATION

Employee Name:_____ Email: _____

Department:_____ Supervisor Name: _____

RESPIRATOR USER HEALTH CONDITIONS

1. Have you used a respirator before? ☐ Yes ☐ No
2. Have you had previous difficulties while using a respirator? ☐ Yes ☐ No
3. Do you have any concerns about your ability to use a respirator safely? ☐ Yes ☐ No
4. Some conditions can seriously affect your ability to safely use a respirator. Do you have or do you experience any of the following or any other condition that **may affect your ability to wear a respirator**? **Check Yes or No only. (DO NOT circle or indicate your medical conditions on this form)** ☐ Yes ☐ No

Allergies	Back/Neck problems	Cardiovascular disease
Asthma	Breathing difficulties	Chest pain on exertion
Dentures	Colour blindness	Chronic bronchitis
Diabetes	Fainting spells	Dizziness/Nausea
Hypertension	Heart problems	Hearing impairment
Pacemaker	Panic Attacks	Shortness of breath
Seizures	Vision impairment	Thyroid problems
Reduced sense of smell	Reduced sense of taste	Neuromuscular disease
Emphysema Lung disease	Temperature susceptibility	Claustrophobia/Fear of heights
Unusual facial features/ Skin conditions	Prescription medication to control a condition	Other condition(s) affecting respirator use

A "YES" answer to any of the above questions indicates further assessment by a health care professional is required prior to respirator use and you will be contacted for this assessment.

Signature of respirator user:_____ Date:_____
dd/mmm/yyyy

CLICK HERE TO SUBMIT FORM

HEALTH CARE PROFESSIONAL PRIMARY ASSESSMENT

Assessment date: _____
dd/mmm/yyyyy

Respirator use permitted: ☐ Yes ☐ No ☐ Uncertain

Referred to medical assessment: ☐ Yes ☐ No

Assessment date: _____
dd/mmm/yyyyy

Name of health care professional (HCP): _____

Title: _____

Signature of HCP: _____

MEDICAL ASSESSMENT (if required)

Assessment date: _____
dd/mmm/yyyyy

☐ Class 1. No restrictions

☐ Class 2. Some specific restrictions apply (specify): _____

☐ Class 3. Respirator use is NOT permitted.

Name of physician: _____

Signature of physician: _____
