



**CONFIDENTIAL WHEN COMPLETED**

**Bluebell Railway (BBR) PLC – Full Steam Ahead 2020**

**Medical Self-Assessment Form**

Name:	Date of Birth:
Address:	Phone:  e-mail:

It is important to be complete and accurate with your answers to this questionnaire, although trivial matters should be ignored (e.g. one episode of transient dizziness while gardening two years ago).

<b>Tick one box for each question</b>		<b>Yes</b>	<b>No</b>	<b>Don't Know</b>
1	Do you have Diabetes needing Insulin?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
2	Have you ever had Blackouts, fits, epilepsy, fainting attacks, recurrent dizziness, or any condition which may cause sudden collapse or incapacity?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
3	Do you get discomfort or pain in the chest, or shortness of breath when exercising – e.g. when climbing a short flight of stairs?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
4	Do you have any difficulty in moving rapidly over short distances, including on slopes, steps or rough ground?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
5	Would you have difficulty in looking over either shoulder?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
6	Are you able to meet the legal eyesight standards for driving a car (with glasses or contact lenses, if normally worn)?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
7	Do you have any difficulty hearing a normal conversation (with hearing aid(s) if normally used)?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
8	Do you have any other impairment of ability to communicate effectively?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>



<b>Tick one box for each question</b>		<b>Yes</b>	<b>No</b>	<b>Don't Know</b>
9	Are you taking any medication that could give you dizziness or drowsiness?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
10	Have you used drugs of abuse (not including alcohol or tobacco) or other substance abuse within the last 12 months?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
11	Have you had any illness related to alcohol in the last 12 months?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
12	Do you have difficulty with or reduction in attention or concentration?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
13	Do you suffer from any mental or nervous disorder (incl. 'nerves')	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
14	Has any doctor advised you to refrain from any work or other activity because of a medical or mental condition, or because of any medication that you are taking?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
15	Do you use hearing aid(s)?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
16	Do you a current valid driving licence?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
17	If the answer to question 16 above is 'No' is this owing to a medical condition?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

The information provided above is complete and correct, to the best of my knowledge

Signed:	Date:
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