COVID-19 Symptoms Checklist

This form must be utilised to ensure that you are free from COVID-19 symptoms and pose limited risk to others

*Required

Date *

DD MM YYYY

Name *

Contact details - email *

Contact details - mobile phone number * *

Are you currently diagnosed with or believe you may have COVID-19? *

- [ ] Yes
- [ ] No

Have you had any of these symptoms of COVID-19 in the past 14 days?

High temperature (fever) *

- [ ] Yes
- [ ] No

A new continuous cough *

- [ ] Yes
- [ ] No

New unexplained shortness of breath *

- [ ] Yes
- [ ] No

Have you been in contact with a COVID-19 confirmed or suspect case in the previous 14 days *

- [ ] Yes
- [ ] No
- [ ] Maybe

If you have answered YES to any of these questions you should stay at home and inform your line manager and medical practitioner. You should follow your territories current Public Health guidance.

Continued overleaf

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Please note the next question is only for medical personnel

Have all infection prevention measures been implemented with the addition of the appropriate Personal Protective Equipment when reviewing patients with confirmed or suspected COVID-19 in the previous 14 days?

- ☐ Yes
- ☐ No
- ☐ N/A