

Return to Day Service Form

Please fill in this form. If you need help, someone can fill it in with you.

Your name	
Your service	



Have you had :

Fever

Yes

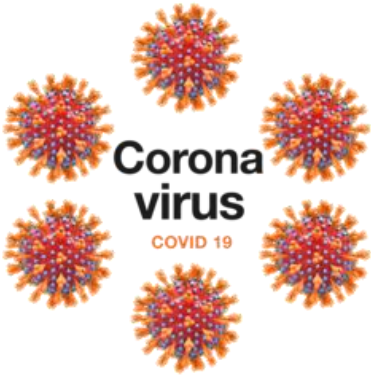


Sore throat

No

Runny nose

Loss of taste or smell

Short of breath

 <p>Corona virus COVID 19</p>	<p>Have you been told you have COVID – 19 in the last 14 days?</p>	<p>Yes <input type="checkbox"/></p> <p>No <input type="checkbox"/></p>
	<p>Have you been near someone who has COVID 19?</p>	<p>Yes <input type="checkbox"/></p> <p>No <input type="checkbox"/></p>
	<p>Have you been told to stay at home?</p>	<p>Yes <input type="checkbox"/></p> <p>No <input type="checkbox"/></p>

Signed	
Print name	
Date	