Health & Safety Covid - 19

NAME

ADDRESS

CONTACT NO

EMAIL

I _____

Declare that I have not had any of the following symptoms over the last 14 days -

Influence type symptoms (coughing, difficulty breathing, fever)

Loss of smell/Taste

Sore Throat

YES _____ NO _____

In the last 14 days have you been in contact with anyone who is known to be suffering from infection by coronavirus?

YES _____ NO _____

Would you consider yourself high risk to corona virus (covid19) for example
Pre - existing medical conditions

YES _____ NO _____

If you answer yes to any of these questions please reschedule your appointment

Signature _____ Date _____

THP
024 7647 3146