Daily Health Form -Working in Frontline Services

Your name	
Your Centre/Service	

	Have you had :	
	Fever	Yes ☐ No ☐
	Loss of taste or smell	Yes ☐ No ☐
	Short of breath	Yes ☐ No ☐
	Cough	Yes ☐ No ☐

	Have you been told you have COVID – 19 in the last 14 days?	Yes ☐ No ☐
	Have you been near someone who has COVID 19?	Yes ☐ No ☐
	Have you been told to stay at home/ cocoon/ self isolate	Yes ☐ No ☐

Signed	
Date	
Your Temp	

You need to fill this form out once each day and keep it with you. You are responsible for holding it for 28 days . You must sign in to any other building you go to during work.

NB: If you answer yes to any of the above questions please return to your car/ remain outside and call your manager.