VISITORS HEALTH CHECK DECLARATION FORM

Name:	**Date:**
Time In :	**Time Out :**
Tempreture :	**Contactact No:**
Purpose:	

Please Answer the following questions:-	**Please circle where Appropriate**	
1. Have you been having a Fever	Y	N
2. Do you have a Cough ?	Y	N
3. Do you have a Sore Throat ?	Y	N
4. Do you have a Runny Nose ?	Y	N
5. Do yo have Shortness of Breath ?	Y	N
6. Do you have a Loss of Sense of Smell ?	Y	N
7. Are you unwell in anyway (besides the above)?		
If "Yes", please indicate. _____	Y	N
8. Are there adult household member who are unwell with fever &/or Flulike symptoms such as cough, runny nose, sore throat, shortness of breath?	Y	N

Signatue : _____