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 ☐ No ☐
	Sore throat	
	Runny nose	
	Loss of taste or smell	
	Short of breath	

Corona virus COVID 19	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?	Yes ☐ No ☐

Signed	
Print name	
Date	