VISITOR HEALTH DECLARATION

	QUESTION	YES	NO
1	Have you been in close contact (<2m for 15minutes or more) with anyone who is confirmed to COVID-19 virus in the last 14 days?		
2	Have you been in close contact (<2m for 15minutes or more) with anyone who is suspected of having COVID-19 virus in the last 14 days?		
3	Do you live in the same household with someone who has symptoms of COVID-19 who has been in isolation within the last 14 days?		
3	Have you been advised by a doctor to self-isolate at this time?		
4	Are you suffering now, or have you suffered any the following symptoms in the past 14 days?		
	A Cough?		
	B Breathing difficulties?		
	C Fever/ High temperature?		
	D Sore Throat		
	E Runny Nose		
	F Flu Like Symptoms		
	G Rash		
	H Loss Of Smell/Taste		
6	Have you been advised by a doctor to cocoon at this time?		
7	Have you returned to Ireland from another country within the last 14 days?		
	If "**YES**", where?		

I confirm that I have responded to the questions above truthfully based on my current condition and I commit to advising the person I am meeting and excluding myself if this situation changes, (i.e. if a point in the future, I would answer " **YES**" to any of the above questions).

NAME:	
SIGNATURE:	
DATE:	
VISITING:	