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Lighter, Stronger, Freer, Faster

SportsPerformancePhysio

Covid-19 Face to Face Client Screening Form

COVID19 Client screening Questionnaire

Medical checklist – This is to confirm and sign that you have no current symptoms of COVID-19 or are within a high-risk medical group. This is required before a face to face contact is considered

In the past 14 days	Yes	No
Have you had a confirmed episode of CV-19, or currently in isolation due to contact with an infected individual?		
Has anybody in your household displayed COVID-19 symptoms within the past 2 weeks?		
Have you been in close contact (<1m for longer than 15 mins without any protection) with confirmed CV-19		
Have you been contacted by the local health authorities to inform you of possible close contact with CV-19		

In the **previous 14 days** has the Client had the following symptoms?

Symptom	Yes	No		Symptom	Yes	No
Fever >37.5degC				Sore throat		
Dry cough				Headache		
Fatigue				Vomiting		
Sputum production				Diarrhoea		
Shortness of breath				Dysgeusia (change in taste)		
Myalgia or arthralgia				Anosmia (change in smell)		

Do you have any underlying medical conditions that classes you in the high-medium risk category?	Yes	No
Immunosuppressed e.g. chemo, radiotherapy		
Severe lung condition		
High dose of steroids medication		
Serious heart condition		
Kidney or liver disease		
Diabetic		
Pregnant (or someone in household)		

Dou you consent to having your contactless temperature measures: YES / NO

I solemnly and sincerely declare that the information I have provided is true and correct and I make this solemn declaration conscientiously believing the same to be true. If any person should suffer as a result of the information being found to be untrue or false, then I am aware that I can be prosecuted for making a false declaration.

Client Signature		Date	
Print Name			