FORM

HEALTH INTERVIEW

NAME_____

DATE_____

WHERE YOU DIAGNOSED WITH SARS COV 19 IN THE LAST 14 DAYS?	○ YES	○ NO
DID YOU HAVE CONTACT WITH THE PERSON DIAGNOSED WITH SARS COV 19 IN THE LAST 14 DAYS?	○ YES	○ NO
DID YOU HAVE CONTACT WITH THE PERSON DIAGNOSED WITH SARS COV 19 IN THE LAST 14 DAYS?	○ YES	○ NO
IS YOUR CHILD / PUPIL OR ANYONE IN YOUR HOUSEHOLD IN QUARANTINE NOW?	○ YES	○ NO
DO YOU OR ANYONE IN YOUR HOUSEHOLD HAVE THE MOST COMMON SYMPHTOMS OF COVID 19 (The most common symptoms of Covid-19 are fever, dry cough, and tiredness. Other symptoms that are less common and may affect some patients include aches and pains, nasal congestion, headache, conjunctivitis, sore throat, diarrhoea, loss of taste or smell or a rash on skin or discoloration of fingers or toes. These symptoms are usually mild and begin gradually)?	○ YES	○ NO
DOES ANYONE IN YOUR HOUSE HAVE THE MOST COMMON SYMPHTOMSIN MENTIONED ABOVE THE LAST 14 DAYS?	○ YES	○ NO

SIGNATURE

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