**Covid-19 Questionnaire / Self-Declaration**

In the interests of the safety of the people at this workplace, their families and the community, Site Management ask that you complete the following questionnaire /self-declaration. Your co-operation and support are appreciated in facilitating this.

|  |  |  |
| --- | --- | --- |
| **Question** | **Yes** | **No** |
| 1. Do you have symptoms of cough, fever, high temperature, sore throat, loss of taste or smell, runny nose, breathlessness or flu like symptoms now or in the past 14 days?
 |  |  |
| 1. Have you been diagnosed with confirmed or suspected COVID-19 infection in the last 14 days?
 |  |  |
| 1. Are you a close contact of a person who is a confirmed or suspected case of COVID-19 in the past 14 days (i.e. less than 2m for more than 15 minutes accumulative in 1 day)?
 |  |  |
| 1. Have you been advised by a doctor or the HSE to self-isolate at this time?
 |  |  |
| 1. Have you been advised by a doctor or the HSE to cocoon at this time?
 |  |  |
| 1. Have you returned to or entered the island of Ireland in the last 14 days?

 If Yes, have you complied with the associated requirements in terms of quarantining & having a PCR test etc., see, [Travel Advice -](https://www.dfa.ie/travel/travel-advice/)  [gov.ie - New rules for travelling to Ireland (www.gov.ie)](https://www.gov.ie/en/publication/77952-government-advice-on-international-travel/#travelling-to-ireland) **Yes:** **No: N/A**If Yes what Country have your travelled from: Date:Proof of travel should be provided e.g., boarding card, ticket etc.If ‘**YES**’, where? \_\_\_\_\_\_\_\_\_\_\_\_\_ **Return date**: **Country:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |  |  |
| 1. Have you any underlying medical condition or in an “At Risk” group?

 **At Risk Group**History of ischaemic heart disease, high blood pressure, history of Stroke/TIA, Type II diabetes, obesity, active malignancy in last 5 years, chronic lung disease, chronic renal disease, chronic liver diseaseHave you discussed this with your medical practitioner and are there any concerns that prohibits you from entering this workplace? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  |  |  |
|  **Additional Questions**  |  |  |
| 1. Are you awaiting a test result for COVID 19?
 |  |  |
| 1. Have you ever tested positive for COVID 19? If **‘YES’** estimated date of onset of symptoms \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
 |  |  |

**Note 1:** If you answer Yes to any of the questions 1-7 above you must forward on the completed form to us. If required, you must contact your GP and follow the medical practitioner’s advice following which you may be required to provide a fit to work cert. On receipt of the information, we will review same as per note 3 below.

**Note 2:** If you answer Yes to question 7, then a specific COVID-19: Individual Risk Assessment for Return to Work will be conducted with you to establish if a return to work at this stage is appropriate. Once completed, we will review same as per note 3 below.

**Note 3:** Please note that this declaration is used to assist management with organizing staff return to work and for arranging work schedules for staff. Following the review, you will be contacted and your return-to-work status will be discussed.

**Note 4:** For contractors and others wishing to enter our work area/sites, this form is used as part of the process to validate suitability.

I confirm that I have responded to the questions above truthfully based on my current condition and I commit to advising the Site Management Team/ Supervisor and excluding myself from this workplace if this situation changes, (i.e. if a point in the future, I would answer **“Yes”** to any of the above questions 1-7).

|  |  |
| --- | --- |
| **Name** |  |
| **Company** |  |
| **Department** |  |
| **Signature** |  |
| **Date** |  |