Helping your Health & Happiness

COVID-19 HEALTH PRE-SCREENING FORM

Please answer these questions prior to your session commencing. This is to help keep everyone safe and healthy – thank you for your understanding.

I confirm: (please tick the box)

1.	I requested a face-to-face session with Lorraine and was aware that I could choose a remote (online) session	
2.	I have read the **COVID-19 Policies & Procedures** that were emailed to me and agree to adhere to any requirements it provides	
3.	I do not have a fever and my recorded non-contact temperature is: (Your temperature **must be less than 37.8** to enable your session to go ahead today)	
4.	I have not had close contact with anyone with respiratory illness or a confirmed case of COVID-19	
5.	In the past 14 days I have not travelled to, or had close contact with anyone who has travelled to a locked down area, a high-risk area, or overseas	
6.	I was not previously shielding either myself or another person at home, and if I was I understand the risks of attending this session and agree to sign the additional disclaimer form	
7.	If my job requires me to wear PPE I confirm that I have worn the required and/or recommended PPE according to the type of duties I was performing (e.g., goggle, gloves, mask and gown) (please mark this N/A if it is not applicable to you)	
8.	I am free from all of the symptoms listed below and have been for the previous 14-days	

If you have ticked to confirm each of the boxes on questions 1 to 8 above
and have no signs or symptoms, you may proceed with your session today.

If you are experiencing any of the following symptoms or have done so in the last 14-days please tick below:
By ticking any of the boxes below to indicate you are experiencing this symptom you understand that your session will not be able to go ahead today and you will be required to reschedule.

❑ New onset of cough	❑ Diarrhoea	❑ Chills
❑ Worsening chronic cough	❑ Runny nose	❑ Headache
❑ Sore throat	❑ Sneezing (not allergy related)	❑ Unexplained fatigue or malaise
❑ Shortness of breath	❑ Hoarse voice	❑ Difficulty swallowing
❑ Difficulty breathing	❑ Nasal congestion	❑ Nausea/vomiting
❑ Abdominal pain	❑ New loss or decrease in sense of taste or smell	

Signature	**Date**
Name (in block capitals)	
Email Address	
Telephone No.	
Please note that disclosure of your details may be required if I am contacted by the NHS contact tracing scheme.	

Session details (for completion following your session by Lorraine Groves)		
Date	**Time**	**Duration**

This signed form will be filed in your Client file and held for the retention period stated.
If you require a copy for your records please let me know and I will happily provide one.