Pre-Return to Work Questionnaire COVID-19

This questionnaire must be completed by staff **at least 3 days** in advance of returning to work.
If the answer is Yes to any of the below questions, you are advised to seek medical advice before returning to work.

Name: _____
Name of School: _____
Name of Principal: _____ Date: _____

	Questions	YES	NO
1.	Do you have symptoms of cough, fever, high temperature, sore throat, runny nose, breathlessness or flu like symptoms now or in the past 14 days?		
2.	Have you been diagnosed with confirmed or suspected COVID-19 infection in the last 14 days?		
3.	Have you been advised by the HSE that you are you a close contact of a person who is a confirmed or suspected case of COVID-19 in the past 14 days?		
4.	Have you been advised by a doctor to self-isolate at this time?		
5.	Have you been advised by a doctor to cocoon at this time?		
6.	Have you been advised by your doctor that you are in the very high risk group? If yes, please liaise with your doctor and Principal re return to work.		

I confirm, to the best of my knowledge that I have no symptoms of COVID-19, am not self-isolating, awaiting results of a COVID-19 test or been advised to restrict my movements. Please note: The school is collecting this sensitive personal data for the purposes of maintaining safety within the workplace in light of the Covid-19 pandemic. The legal basis for collecting this data is based on vital public health interests and maintaining occupational health and will be held securely in line with our retention policy.

Signed: _____