

Employee Health Questionnaire

As the Coronavirus Disease (COVID-19) outbreak continues to evolve, we are conducting a simple screening questionnaire in order to reduce any potential risk of exposure to our employees, customers and visitors.

Full Name:	Phone / Mob. No:	
Date:	Time of visit:	
Visitor Company/ Organisation Name:	Purpose of Visit:	Contact Person:

Self-Declaration by Employee

COVID-19 specific

1.	Have you or a cohabitant or a close member of your family travelled outside of Ireland (excluding Northern Ireland) in the last 14 days? Yes ___ No ___ If yes, countries visited: _____
2.	Have you or a cohabitant or a close member of your family been in contact with or near (3 meters) anyone who is now diagnosed to have COVID-19 (Coronavirus)? Yes ___ No ___
3.	Have you experienced any cold or flu-like symptoms (to include fever, persistent cough, sore throat, respiratory illness, difficulty breathing) in the last 14 days? Yes ___ No ___
4.	Have you or a cohabitant or a close member of your family been in a hospital or care facility which has experienced a known outbreak of the virus in the last 14 days? Yes ___ No ___
5.	Are you or a cohabitant or a close member of your family in a school or workplace which has been closed as a result of an outbreak in the last 14 days? Yes ___ No ___
6.	Temperature reading: _____ °C <i>Temperature should be between 36.5-37.5°C.</i>
If you have answered YES to ANY of the above or if temperature reading is out of recommended temperatures, please note you are NOT PERMITTED TO COME TO SITE AND YOU WILL NOT BE ADMITTED ACCESS.	

GENERAL MEDICAL QUESTIONNAIRE

7.	Have you suffered from any sickness, diarrhoea or stomach complaint recently? Yes ___ No ___
8.	Have you recently suffered from boils, discharge from ears, eyes or nose? Yes ___ No ___
9.	Have you ever suffered from or come in contact with typhoid, paratyphoid or cholera? Yes ___ No ___

10.	Are you or have you ever suffered from any contagious disease which would pose a food risk? <div style="text-align: right;">Yes ___ No ___</div>
11.	Are you suffering from any infections of the skin, nose, throat, ears or eyes? <div style="text-align: right;">Yes ___ No ___</div>
	If you have answered yes to any of the questions above, please give details in the space provided:
	Employee's Signature:
Received by:	
Full Name: (Block Capitals)	Signature:

Access to premises: denied / approved (circle one).

Notes for Reception/Security

- Please do not permit entry to site to any employee who has answered YES to questions above 2-5 above and inform Management immediately.
- **Please request the point of contact to leave site**