Have you had the recent onset of a new continuous cough?

☐ **Yes**
☐ **No**

Do you have a high temperature?

☐ **Yes**
☐ **No**

Have you noticed a loss of, or change in, normal sense of taste or smell?

☐ **Yes**
☐ **No**

In the past week have you come into contact with a person suspected of infection or infected with Covid-19?

☐ **Yes**
☐ **No**

Name___________________ Date___/___/_______

Signature___________________