Section 1: Class Details

Location:

Date & Time:

Section 2: Please answer the following questions

1. Do you currently have any of the following symptoms?	YES	NO
• Fever/High Temperature (above 38 degrees)	☐	☐
• Cough	☐	☐
• Shortness of Breath	☐	☐
• Breathing Difficulties	☐	☐
• Fatigue	☐	☐
• Sore Throat	☐	☐
• Loss of taste or smell	☐	☐
2. Have you been in close contact with anyone who was confirmed as having COVID-19?	☐	☐
3. Do you live in the same household with someone who has symptoms of COVID-19 or who has been in isolation within the last 14 days?	☐	☐
4. Have you returned to the island of Ireland from another country within the last 14 days?	☐	☐

Section 3: Declaration

Name:

Date:

Signed: