# **VISITOR SELF DECLARATION FORM**

|  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- |
| If you answer YES to any of the below questions you should NOT attend your club and before you return you should follow appropriate medical advice and guidelines. | | | | | | | | |
| Questions | | | | | | **Yes** |  | **No** |
|  |  | | | | |  |  |  |
| 1 | Have you been in close contact with anyone who is confirmed to have had COVID-19 virus in the last 14 days? | | | | |  |  |  |
|  |  | | | | |  |  |  |
| 2 | Have you been in close contact with anyone who is suspected of having COVID-19 virus in the last 14 days? | | | | |  |  |  |
|  |  | | | | |  |  |  |
| 3 | Do you live in the same household with someone who has symptoms of COVID-19 who has been in isolation in the last 14 days? | | | | |  |  |  |
|  |  | | | | |  |  |  |
| 4 | Have you been advised by a doctor to self-isolate at this time? | | | | |  |  |  |
|  |  | | | | |  |  |  |
| 5 | Are you suffering now, or have you suffered any of the following symptoms in the past 14 days? | | | | |  |  |  |
|  |  | | | | |  |  |  |
|  |  | **Yes** |  | **No** |  | **Yes** |  | **No** |
|  | Cough |  |  |  | Runny Nose |  |  |  |
|  | Breathing Difficulties |  |  |  | Flu Like Symptoms |  |  |  |
|  | Fever / High temperature |  |  |  | Rash |  |  |  |
|  | Sore Throat |  |  |  | Loss of Smell / Taste |  |  |  |
|  |  | | | | |  |  |  |
| 6 | Have you been advised by a doctor to cocoon? | | | | |  |  |  |
|  |  | | | | |  |  |  |
| 7 | Have you returned to Ireland / Northern Ireland within the last 14 days from a country listed by Government, which requires individuals to self-isolate or restrict their movements on their return? | | | | |  |  |  |
|  |  | | | | |  |  |  |
| 8 | If “**YES”**, WHERE? *Insert name of country \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_* | | | | |  |  |  |
| If you answer yes to any of the questions 1-6 in the above section of this Pre-return Self Declaration form, you must receive a medical examination & clearance from your GP to participate in Special Olympics Ireland activities | | | | | | | | |
|  | Name: | | | | |  |  |  |
|  | BLOCK CAPITALS | | | | |  |  |  |
|  | Signature: | | | | |  |  |  |
|  | Date: | | | | |  |  |  |