

COVID-19 DECLARATION FORM

FULL NAME		
FULL ADDRESS		
POST CODE		
DATE OF BIRTH		
EMAIL ADDRESS		
MOBILE NUMBER		
TESTING		
Have you had a Covid-19 test? If yes, when? Antigen or antibody test? Antigen – tests for Covid-19 on day of testing. Antibody – possible immunity	YES <input type="checkbox"/>	NO <input type="checkbox"/>
Date:		
If it was a positive result, has the isolation period expired?	YES <input type="checkbox"/>	NO <input type="checkbox"/>
Do you still have symptoms?	YES <input type="checkbox"/>	NO <input type="checkbox"/>
Are you registered with the a Test & Trace app?	YES <input type="checkbox"/>	NO <input type="checkbox"/>
SYMPTOMS - Are you experiencing any of the following?		
Severe breathing difficulties or chest pain	YES <input type="checkbox"/>	NO <input type="checkbox"/>
Difficulty in waking or confusion	YES <input type="checkbox"/>	NO <input type="checkbox"/>
If yes to any of the above call 999		
Fever	YES <input type="checkbox"/>	NO <input type="checkbox"/>
Onset, or worsening of a cough	YES <input type="checkbox"/>	NO <input type="checkbox"/>
Sore throat or runny nose	YES <input type="checkbox"/>	NO <input type="checkbox"/>
Chills or headache	YES <input type="checkbox"/>	NO <input type="checkbox"/>
Pain swallowing	YES <input type="checkbox"/>	NO <input type="checkbox"/>
Muscle & joint ache	YES <input type="checkbox"/>	NO <input type="checkbox"/>
Fatigue or exhaustion	YES <input type="checkbox"/>	NO <input type="checkbox"/>
Loss of taste or smell	YES <input type="checkbox"/>	NO <input type="checkbox"/>
If any of the above, the advice is to self-isolate for 7 days. A Covid-19 test may be necessary, call 119		
Shortness of breath or difficulty lying down due to chest issues	YES <input type="checkbox"/>	NO <input type="checkbox"/>
If any of the above, call 111		

Have you been in contact with anyone with Covid-19 symptoms?	YES <input type="checkbox"/>	NO <input type="checkbox"/>
Have you recently been hospitalised?	YES <input type="checkbox"/>	NO <input type="checkbox"/>
If so, why:		
Do you have any of the following health issues		
High blood pressure or other heart condition	YES <input type="checkbox"/>	NO <input type="checkbox"/>
Diabetes Type 1 or 2 – if so, which?	YES <input type="checkbox"/>	NO <input type="checkbox"/>
Cancer	YES <input type="checkbox"/>	NO <input type="checkbox"/>
Lung condition	YES <input type="checkbox"/>	NO <input type="checkbox"/>
Any other conditions – please list:		
If you have had Covid-19:		
Are you experiencing post Covid-19 circulatory complications (deep vein thrombosis, micro-embolisms, stroke symptoms or pulmonary embolism)	YES <input type="checkbox"/>	NO <input type="checkbox"/>
Are you?		
An NHS front line worker	YES <input type="checkbox"/>	NO <input type="checkbox"/>
A carer – home or care home	YES <input type="checkbox"/>	NO <input type="checkbox"/>
Shielding a vulnerable adult	YES <input type="checkbox"/>	NO <input type="checkbox"/>
Pregnant – how many weeks?	YES <input type="checkbox"/>	NO <input type="checkbox"/>
Aged over 70	YES <input type="checkbox"/>	NO <input type="checkbox"/>
Allergic to latex gloves or specific cleaning products	YES <input type="checkbox"/>	NO <input type="checkbox"/>

SIGNED

I solemnly and sincerely declare that the information I have provided is true and correct and I make this solemn declaration conscientiously believing the same to be true. If any person should suffer as a result of the information being found to be untrue and false, then I am aware I can be prosecuted for making a false declaration.

If either I or someone I have been in contact with tests positive for Covid-19 or have been contacted by NHS Test & Trace I will inform you.

Full name:

Date:

Please return this form to physio@kent.ac.uk at least 48 hours before your appointment