Irish Tai Chi Chuan Association

COVID-19 PRE-RETURN FORM - Client / Student

Name	
Appointment date	

	Signed
To be best of your knowledge can you confirm you have no symptoms of COVID-19	
Please confirm that you are not self-isolating and are not awaiting COVID-19 test results	

	Yes	No
Do you have symptoms of cough, fever, high temperature, sore throat, runny nose, breathlessness or flu like symptoms now or in the last 14 days- Please indicate yes/no opposite		
Have you been diagnosed with confirmed or suspected COVID-19 infection in the last 14 days.		
Are you a close contact of a person who is confirmed or suspected case of COVID-19 in the past 14 days? (i.e. less than 2m for more than 15 minutes accumulative in one day)		
Have you been advised by a doctor to self-isolate at this time?		
Have you been advised by a doctor to cocoon at this time?		

If there are any changes in symptoms, suspected or confirmed COVID-19 infection, close contact with a suspected/confirmed case, doctors advice on isolation etc after you return to work then please inform your instructor or therapist re same.

Signed _____ Date _____