COVID CHECKLIST

Allcare Pharmacy

PATIENT NAME: ____________________

GUARDIAN NAME: ____________________

ADDRESS: ____________________

CONTACT NUMBER: ____________________

	Pharmacist	Patient	Guardian
Temperature (˚C)			
Are you experiencing any of the following symptoms?			
Dry Cough			
Fever			
Shortness of Breath			
Loss or change to sense of smell or taste			

Have you been diagnosed with or suspected as having COVID-19 infection in the last 14 days?

____

Have you recently returned to Ireland from a 'high risk' COVID area?
Please provide detail

____

Are you classified as immunocompromised or on medication that affects your immune system?

____

Have you been in close contact with a person who is a confirmed or a suspected case of COVID-19 in the past 14 days?

____

Patient/Guardian Signature: ____________________ Date: ____________________

Pharmacist Signature: ____________________ Date: ____________________