Appendix 2

Return to Work Form

This form must be completed by staff in advance of returning to work.
If the answer is Yes to any of the below questions, you are advised to seek medical advice before returning to work.

Name: _____
Name of School: _____
Name of Principal: _____Date: _____

	Questions	YES	NO
1.	Do you have symptoms of cough, fever, high temperature, difficulty breathing, loss or change in your sense of smell or taste now or in the past 14 days?		
2.	Have you been diagnosed with confirmed or suspected COVID-19 infection in the last 14 days?		
3	Are you awaiting the results of a COVID-19 test?		
4	In the past 14 days, have you been in contact with a person who is a confirmed or suspected case of COVID-19?		
5	Have you been advised by a doctor to self-isolate at this time?		
6	Have you been advised to restrict your movements at this time?		
7	Have you been advised to cocoon at this time? Note: if you're at very high risk (extremely vulnerable) from COVID-19 you may be advised to cocoon.		

I confirm, to the best of my knowledge that I have no symptoms of COVID-19, am not self-isolating or awaiting results of a COVID-19 test and have not been advised to restrict my movements.
Please note: The school is collecting this sensitive personal data for the purposes of maintaining safety within the workplace in light of the COVID-19 pandemic. The legal basis for collecting this data is based on vital public health interests and maintaining occupational health and this data will be held securely in line with our retention policy.

Signed: _____