



PUPIL NAME : _____ **CLASS :** _____

PUPIL HEALTH RISK ASSESSMENT	DATE :	
	<u>YES</u>	<u>NO</u>
1. Does the child currently have a high temperature and/or dry persistent cough? <i>(If yes please provide further details below)</i>	<input type="checkbox"/>	<input type="checkbox"/>
2. Does anyone in the child's household have a high temperature and/or dry persistent cough? <i>(If yes please provide further details below)</i>	<input type="checkbox"/>	<input type="checkbox"/>
3. Is anyone in the child's household self-isolating? <i>(If yes please provide further details below)</i>	<input type="checkbox"/>	<input type="checkbox"/>
4. Does the child currently have any cold or flu like symptoms? <i>(If yes please provide further details below)</i>	<input type="checkbox"/>	<input type="checkbox"/>
5. Does the child have any other health conditions that staff need to be aware of? <i>(If yes please provide further details below)</i>	<input type="checkbox"/>	<input type="checkbox"/>
FURTHER INFORMATION:		
PARENT / GUARDIAN SIGNATURE :		