CHECKLIST

Blood donor “entry health questionnaire” to reduce the risk of COVID-19 infection

Surname and name: .... Date of birth:.....

Residence: ....

Tel. number: ....e-mail:.....@.....

Temperature: ……. ° C Measured (signature): ....

(circle the correct answer)

T> 37.0 ° C	YES	NO
During the last 14 days I have been abroad	YES	NO
During the last 14 days I have been in contact with a person who has returned from abroad, is quarantined or has symptoms of respiratory disease or COVID-19	YES	NO
I have or during the last 14 days I have had any of the following symptoms of respiratory disease: sore throat, dry cough, shortness of breath, fever, chills, headache, muscle aches, diarrhea or vomiting	YES	NO
I was infected with COVID-19	YES	NO

If yes, date of control negative RNA test – nasopahryngeal swab .....

Date: …… Donor's signature: ..... ……