CHECKLIST

Blood donor´s “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 by (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, has been quarantined or has had a 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 positive test for COVID-19 (RT PCR or antigen test)

.....

I was vaccinated against COVID-19 YES NO

If yes, date of vaccination

.....

Date: …… Donor's signature: .....
……

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