

UNILABS PROTECT™ PROGRAMMES



EMPLOYEE ID:

DATE:

POSITIVE COVID-19 DIAGNOSIS: YES NO

RELEVANT SYMPTOMS

SYMPTOMS	LAST 3 DAYS	LAST 10 DAYS	LAST 3 WEEKS
Cough*	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Shortness of breath or difficulty breathing*	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Fever*	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Runny nose	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Sore throat	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Diarrhea and/or vomiting	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
New loss of taste or smell	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

CONTACT TRANSMISSION RISK	LAST 3 DAYS	LAST 10 DAYS	LAST 3 WEEKS
Close contact with confirmed Covid infected person	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Our Medical experts consider symptomatic:

- Any main symptoms in thee last 3 days
- Main symptoms (*)