Visitor Information		
Name:	Relationship to Resident:	
Childs Name:	Age:	Relationship to visitor:
Contact Number:	Contact number (Mobile number/Home):	
Name of Resident being visited:		
Date and Time of Visit:		
DECLARATION BY VISITOR (ALL QUESTIONS ARE MANDATORY)		
Have you been in close proximity within the last 14 days with any person who has tested positive for COVID 19?	**YES**	**NO**
Have you been in close proximity to any person experiencing flu like symptoms within the last 14 days?	**YES**	**NO**
Have you tested Positive for COVID 19 within the last 14 days or have you experienced flu like symptoms within the last fourteen days?	**YES**	**NO**
Have you visited a foreign country or been asked to quarantine following a visit to a foreign country within the last 14 days?	**YES**	**NO**
Are you experiencing any of the symptoms relating to COVID 19? a. new continuous cough and/or b. high temperature and/or c. loss of, or change to, sense of smell or taste	**YES**	**NO**

Are you experiencing any other symptoms which may or may not be related to COVID 19? For example, are you unwell in any way with diarrhoea, vomiting or other new symptoms in the last 48 hours?	**YES**	**NO**
If accompanied by a child, has the child been in close proximity within the last 14 days with any person who has tested positive for COVID 19?	**YES**	**NO**
Has the child had any illnesses in the last 14 days unrelated to Covid 19?	**YES**	**NO**
If you have answered yes to any of the above questions, visiting would not be appropriate as you are putting the person you are visiting and others at risk. If you have had a recent negative test for COVID-19, please bring the details with you.		
Have been told to stay at home, self-isolate or shield for health reasons	**YES**	**NO**
If YES, please discuss with the home manager prior to any visit		
PROTOCOLS TO BE MAINTAINED THROUGHOUT THE VISIT		
We ask that you sign to declare that you agree to abide by the following protocols throughout the duration of the visit		
I agree to maintain social distancing rules of 2m and not to have any physical contact with the person that I am visiting unless I have tested negative by use of an LFD test	I agree to not directly or indirectly give to the person I am visiting any items I have brought in with me	
I agree to only visit for a thirty-minute period and I will not vacate the area where the visit is to take place without permission being gained from a staff member	I understand that the visit is at the full discretion of the Home Manager and any violation of the protocols will result in the visit being terminated	
I agree not to use any form of recording equipment or camera	Date:	
Signed: Print Name:		

VISITOR CONSENT FORM
Lateral Flow Testing for Coronavirus/Covid-19

Name of Individual you are visiting:	Your full name, and home address: -
Date of visit:	Time of visit:

I consent to having a Lateral Flow Test prior to my visit.	
1) I agree that a nominated staff member may register my data with the NHS on my behalf. 2) I understand that if my test shows a positive result, I will not be allowed to visit, and I may be contacted by the NHS Test and Trace Team. 3) I will be required to take a confirmatory PCR swab which will be registered on the NHS portal. 4) I agree for my Information to be shared with the NHS. 5) I understand that if I choose to visit without using the visitors screen, I will need to complete a Lateral Flow Test at every visit	**Y/N** **Y/N** **Y/N** **Y/N**
I agree to the following guidelines whilst in the service: 1) I will wear the personal protective equipment provided by staff and I will not remove it until asked to do so. 2) I agree to stay in the agreed visitor location unless directed to leave by a member of staff. 3) I agree to give any gifts to staff so they can be sanitized prior to being given to the Individual.	**Y/N** **Y/N** **Y/N**

YES, I have read the consent form, I give consent to be tested for Coronavirus/ Covid-19 using the Lateral Flow Test.	**Highpoint Care representative** The visitor has completed the consent form correctly and agreed to the test.
Name	Name
Signature (visitor)	Signature – (Highpoint Care)
Date	Date
If 'No' please give reason(s)	

For office use

The visitor has taken their own LFT test on the same day as their visit. **Y/N**

The visitor has provided evidence of a negative LFT test which has been taken. on the same day as their visit or on the same day as taking their family member/ friend out of the home for a visit. **Y/N**

I confirm that the result is Negative.

Signed……. Date……..