



## MOTORSPORT SOUTH AFRICA - DAILY SCREENING QUESTIONNAIRE

NAME/S			
SURNAME			
ID NUMBER			
CELL NUMBER			
FEMALE <input type="checkbox"/>	MALE <input type="checkbox"/>		
TEMPERATURE READING			
DATE			
TIME			
SYMPTOMS	YES	NO	COMMENTS
Cough	<input type="checkbox"/>	<input type="checkbox"/>	
Sore Throat	<input type="checkbox"/>	<input type="checkbox"/>	
Shortness Of Breath	<input type="checkbox"/>	<input type="checkbox"/>	
Nausea/Vomiting/Diarrhoea	<input type="checkbox"/>	<input type="checkbox"/>	
Fever/Chills Or (High Temperature = 37.5°c)	<input type="checkbox"/>	<input type="checkbox"/>	
Loss Of Taste	<input type="checkbox"/>	<input type="checkbox"/>	
Loss Of Sense Of Smell	<input type="checkbox"/>	<input type="checkbox"/>	
Body Aches	<input type="checkbox"/>	<input type="checkbox"/>	
Fatigue/Weakness/Tiredness	<input type="checkbox"/>	<input type="checkbox"/>	
Persistent Pain Or Pressure In The Chest	<input type="checkbox"/>	<input type="checkbox"/>	
DETAILS OF CONFIRMED CASE	YES	NO	REMARKS
Have you had contact with anyone with cold/flu like illness in the last 14 days?	<input type="checkbox"/>	<input type="checkbox"/>	
Have you been diagnosed with the Coronavirus infection in the last 14 days?	<input type="checkbox"/>	<input type="checkbox"/>	
Have you had any contact with a confirmed COVID-19 case in the last 14 days?	<input type="checkbox"/>	<input type="checkbox"/>	
<b>NAME OF EVENT:</b>			
<b>NAME OF VENUE:</b>			
<b>DATE OF EVENT:</b>			