	COVID-19 SYMPTOMS SCREENING QUESTIONNAIRE	

Name and surname		**Member No.**	
Date of Birth		**Occupation**	
Affiliate		**Club/ Swim School**	

SIGNS (EXAMINATION)	YES	NO
Does the member have fever /chills (measured temperature with a thermometer)		
Is the member's eyes red?		
Do you have a cough?		
Do you have shortness of breath?		
Do you have sore throat?		
Do have a recent loss of taste?		
Do have a recent loss of smell?		
Are you nauseas?		
Are you vomiting?		
Are you having diarrhoea?		
Are you experiencing other flu like symptoms (weakness or tiredness)?		
Do you experience body pain/body aches?		

EXPOSURE WITHIN THE PAST 14 DAYS	YES	NO
Have you had contact with a confirmed COVID-19 positive person?		
Have you had contact with a probable COVID- 19 positive person?		
Have you travelled to identified hotspot areas with local transmission of SARS-CoV-2; (NB Affected countries/cities/districts will change with time, consult the NICD website for current updates)		
Have you travelled to high risk areas?		
Did you sleep in a hotel or lodge/guesthouse?		
Were you ever been admitted in the hospital or visited doctor's rooms since lockdown started?		
Have you visited or currently live in high COVID-19 prevalence area?		

COMMENTS

Name of Person completing questionnaire	Signature	Date

Name of Compliance Officer	Signature of Compliance Officer	Date