



MOTORSPORT SOUTH AFRICA - DAILY SCREENING QUESTIONNAIRE

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