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			

DETALS 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:	