# COVID-19 DAILY SELF ASSESSMENT SCREENING QUESTIONNAIRE
# (to be handed in at the access point and/or completed at the access point)

**If you answer YES to any of the symptom questions you should not come to work, if you do you will not be permitted to enter the workplace.**

| | |
|---|---|
| Name of Staff Member | |
| Identity number of staff member | |
| Staff number (staff only) | |
| Address | |
| Last screening date | |

| **Do you have any of the following symptoms?** | | |
|---|---|---|
| Fever (high temperature, higher than 37.5 celcius) | Yes | No |
| Cough | Yes | No |
| Sore throat | Yes | No |
| Shortness of breath | Yes | No |
| Myalgia (general weakness) | Yes | No |
| Loss of taste (ageusia) | Yes | No |
| Loss of sense of smell (anosmia) | Yes | No |
| Body aches | Yes | No |
| Redness of the eyes | Yes | No |
| Nausea/vomiting/diarrhoea | Yes | No |

| | | |
|---|---|---|
| Have you travelled outside the province in the past 14 days?<br>If yes, where:_____ | Yes | No |
| Have you had contact with someone that has tested positive for Covid 19 in the past 14 days? | Yes | No |

| | |
|---|---|
| I hereby certify that the information I have provided in this form is complete, true and accurate and I give permission for the company to validate any information provided. | |
| In line with the Protection of Personal Information Act, you are required to give permission for the company to check the accuracy of any information provided. Should it become apparent that the information you have provided is false our disciplinary procedures and processes will apply. | |
| Signature | |
| DATE | |