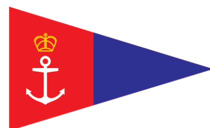

ROYAL CAPE YACHT CLUB
COVID ASSESSMENT FORM

Date and Time: ____________________

Name and Surname: ____________________

Contact Number: ____________________

Company: ____________________

Email address: ____________________

Temperature: ____________________

Reason for Visit: ____________________

Please answer the following questions honestly as they are in the best interest of our staff and members. Have you displayed any of the symptoms below - please circle:

Fever (>38 ◦ C) or a history of a fever in the last 14 days
Cough
Redness of eyes
Nausea
Sore Throat / Shortness of breath

Difficulty breathing
Vomiting
Loss of smell or taste
Diarrhoea
Fatigue
Weakness or Tiredness

Were you in close contact with a confirmed COVID-19 or a person under investigation for COVID-19?

Have you been in close contact with or are you living with anybody with flu like symptoms?

Have you been in contact with somebody with flu like symptoms and a negative or inconclusive COVID-19 TEST?

Have you worked in, or attended another health care facility where COVID-19 patients are tested? If YES, please specify which health facility.

Were you admitted with severe pneumonia?

SIGNATURE

DATE