COVID-19 VISITOR ENTRY FORM

DATE:_____

NAME		
ADDRESS		
CONTACT INFORMATION	CONTACT NUMBER	EMAIL

HAVE YOU OR ANYONE RESIDING WITH YOU TRAVELLED IN THE LAST 14 DAYS?	YES ☐	NO ☐

IF SO PLEASE STATE THE COUNTRY_____

HAVE YOU OR ANYONE RESIDING WITH YOU BEEN IN CONTACT WITH A PERSON(S) WHO WAS AFFECTED BY COVID-19 IN THE LAST 14 DAYS?	YES ☐	NO ☐

DO YOU OR ANYONE RESIDING WITH YOU HAVE ANY OF THE FOLLOWING SYMPTOMS?

- ☐ LOSS OF TASTE OR SMELL
- ☐ CONGESTION OR RUNNY NOSE
- ☐ FEVER
- ☐ BODY ACHES
- ☐ SORE THROAT
- ☐ FATIGUE
- ☐ HEADACHE
- ☐ COUGH
- ☐ NAUSEA/VOMITTING
- ☐ SHORTNESS OF BREATH
- ☐ SNEEZING
- ☐ DIARRHOEA

TEMPERATURE RECORDED	