RETURN TO LTS LESSONS COVID19 SYMPTOMS SCREENING QUESTIONNAIRE

THIS DOCUMENT IS TO BE COMPLETED, SIGNED, DATED AND RETURNED TO RAPID AQUATICS SWIM SCHOOL BEFORE THE SWIMMER COMMENCES LESSONS FOR THE 2020-21 SEASON

SWIMMERS NAME		**SSA NO**	NONE
DATE OF BIRTH		**PROVINCE**	KZN

SIGNS (EXAMINATION)	**YES**	**NO**
Do you have signs of fever or chills?		
Are your eyes red?		
Do you have a persistent cough?		
Do you have a shortness of breath?		
Do you have a sore throat?		
Do you have a recent loss of taste?		
Do you have a recent loss of smell?		
Are you nauseous?		
Are you vomiting?		
Are you experiencing diarrhoea?		
Are you experiencing other flu like symptoms? (weakness or tiredness)		
Are you experiencing body pains or aches?		

EXPOSURE WITHIN THE PAST 14 DAYS	**YES**	**NO**
Have you had contact with a person confirmed with Covid 19?		
Have you had contact with a person suspected of having Covid 19?		
Have you travelled to an identified Covid 19 hotspot? (please state)		
Have you travelled to any high risk areas? (please state)		
Have you been in a different country? (please state)		
Did you sleep in a guesthouse/lodge or hotel?		
Have you been admitted to hospital?		
Have you visited a doctor?		

Name of person completing the questionnaire (parent if swimmer is under 18)	**Signature:**	**Date:**

Name of Compliance Officer	**Signature:**	**Date:**