SAFCEC
READY TO DELIVER

National Office

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COVID-19

EMPLOYEE SCREENING QUESTIONNAIRE GUIDELINE

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COVID-19 EMPLOYEE SCREENING QUESTIONNAIRE

Surname:		First Name:		ID Number	
Date Of Birth:		Occupation:		Department:	
Contractor (If applicable)		Age:			

1.	Are you above the age of 60?	Yes	No
2.	Have you recently travelled to any high-risk country or any high-risk area defined under the National Disaster Regulations? (Please ask Person on Duty to explain this question)	Yes	No
3.	Have you in the past two weeks interacted with a person who has been found Covid-19 positive?	Yes	No
	If YES, provide details.		
4.	Do you suffer from any of the following conditions in a non-medicated or non-controlled manner?		
	Hypertension	Yes	No
	Diabetes	Yes	No
	Epilepsy	Yes	No
	Asthma	Yes	No
	TB	Yes	No
	Pregnant	Yes	No
	If yes and symptomatic, or any vital signs out of normal limits, refer to the medical service provider		
5.	Symptom Check		
	Fever	Yes	No
	Cough	Yes	No
	Sore Throat	Yes	No
	Shortness of breath	Yes	No
	Body aches	Yes	No
	Loss of Smell	Yes	No
	Loss of taste	Yes	No
	Nausea	Yes	No
	Vomiting	Yes	No
	Diarrhoea	Yes	No
	Fatigue	Yes	No
	Weakness or tiredness	Yes	No
	If any symptoms are present refer the employee to the isolation area		

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1.	Temperature Measurement Result if Performed	
	Decision on Access (Tick appropriate box)	
2.	Access issued	
	Refer to isolation area	
	Refer to medical service provider	

	Name	Designation	Signature
Assessment done by			
Date			

I hereby declare that all the information furnished above is, to the best of my knowledge, true and correct and that no information has been omitted or withheld. I hereby grant …………………………..(Company Name) permission to make use of the information contained in this document to determine my personal Covid-19 risk on site.

Signature of employee: ______________________________