



**APPENDIX 1**

HEALTH QUESTIONNAIRE: SCREENING FOR COVID-19							
THIS QUESTIONNAIRE IS TO BE COMPLETED BY EACH PERSON AT THE COMPETITION VENUE							
1.	Date:						
2.	First Name						
3.	Surname						
4.	Cell phone number						
5.	Identity/passport number						
6.	Date of birth/Age						
7.	Sex	Male	<input type="checkbox"/>	Female	<input type="checkbox"/>	Other	<input type="checkbox"/>
8.	Home address						
9.	Temporary address						
10.	Temperature						
11.	Do you experience any of the following signs and symptoms ?						
a)	Fever	YES	<input type="checkbox"/>	NO	<input type="checkbox"/>		
b)	Cough	YES	<input type="checkbox"/>	NO	<input type="checkbox"/>		
c)	Shortness of breath	YES	<input type="checkbox"/>	NO	<input type="checkbox"/>		
d)	Sore throat	YES	<input type="checkbox"/>	NO	<input type="checkbox"/>		
e)	Loss of taste	YES	<input type="checkbox"/>	NO	<input type="checkbox"/>		
f)	Loss of smell	YES	<input type="checkbox"/>	NO	<input type="checkbox"/>		
12.	Covid-19 testing						
a)	Have you tested positive for Covid-19 in the past 14 days?	YES	<input type="checkbox"/>	NO	<input type="checkbox"/>		
b)	Have you been in contact with someone who tested positive for Covid-19 in the past 14 days?	YES	<input type="checkbox"/>	NO	<input type="checkbox"/>		
If all negative, entry will be allowed.							
If any positive and/or temperature >38 degrees, refer to local health authorities; not allowed in the stadium.							
ALL SECTIONS ARE COMPULSORY AND MUST BE COMPLETED							
ALL INFORMATION WILL BE TREATED ONFIDENTIALLY							