COVID-19 SCREENING QUESTIONNAIRE

Name and Surname: _____

Grade / Class: _____

Date: _____

Please answer the following questions honestly:

Do you have any of the following symptoms?

1. Temperature more than 38□C?	Yes	No
2. Continuous cough? / Dry cough?	Yes	No
3. Sore throat?	Yes	No
4. Difficulty in breathing?	Yes	No
5. Were you in close contact with a confirmed Coronavirus (Covid-19) person in the last 14 days?	Yes	No

Have you been diagnosed with any of the following conditions?

a.	Diabetes	Yes	No
b.	Hypertension	Yes	No
c.	Cardiac disease	Yes	No
d.	Respiratory disease e.g. Asthma	Yes	No

This form must be completed and send with each learner.

NO FORM, means NO ENTRY into the school.

Please note that we will inform each Year group when to come back to school.
A SMS will be send to parents / guardians.