HIGHER HEALTH

Higher Education & Training: Health, Wellness and Development Centre

COVID-19 Screening Tool

Date: ________________________________ **Staff/Student Number: _________________________**

Province				
TVET/University Name				
Campus Name				
Date				
Name & Surname of person being screened				
Cell Number				
Age	<18	18 – 39	40 – 65	>65
Gender	Male	Female	Other	Rather not say
Address				
Designation	Student	Staff	Visitor	Other
1. Do you feel very hot or cold? Are you sweating or shivering? When you touch your forehead, does it feel hot?	Yes		No	
2. Do you have a cough that recently started?	Yes		No	
3. Do you have a sore throat or pain when swallowing?	Yes		No	
4. Do you have breathlessness or a difficulty breathing, that you've noticed recently?	Yes		No	
5. Have you noticed any recent changes in your ability to taste or smell things?	Yes		No	
6. Have you been in close contact to someone confirmed to be infected with COVID19?	Yes		No	
7. Do you have a pre-existing medical condition we should be aware of (e.g. obesity, diabetes, hypertension, cardiovascular disease)?	Yes		No	
8. Please confirm that the information you shared is accurate to the best of your knowledge and that you give the National Department of Health permission to contact you if necessary?	Yes		No	

Risk Classification

Has the person answered yes to any question between 1 -7? If so, indicate the number of that question.	Action Taken	If referred, indicate to where	Was the person briefed on the precautions to take or given any IEC material?

Temperature Reading (in degree celsius) if available	

Clearance:	Granted	Denied

Name & Surname of Person doing the Screening: ____

Signature: _________________________________

Date: ________________________