**GUEST INFORMATION FORM – COVID-19**

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| RIGHT OF CONVEYANCE OR ADMISSION RESERVED |

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| We appreciate that we are asking for more information than usual. This information is to ensure we can address appropriately any risks should you or one of our guests or our staff become ill with suspected COVID-19, and to ensure that in such an event, the required contact tracing can be carried-out. All information provided will only be shared with authorised persons.  **NOTE:** As per the regulations to the Disaster Management Act, 2002 published on 17 March 2020, any persons who intentionally –   1. Misrepresents that he / she / any other person is infected with COVID-19 is guilty of an offence and on conviction can be fined and / or imprisoned (for up to 6 months) 2. Exposes another person to COVID-19 may be prosecuted for an offence, including assault, attempted murder or murder. |

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| GUEST DETAILS | | | |
| NAME |  | SURNAME |  |
| ID / PASSPORT NO. |  | | |
| CONTACT NO. / CELL NO. |  | | |
| EMAIL ADDRESS |  | | |
| COUNTRY / PLACE / TOWN OF RESIDENCE |  | | |
| EMERGENCY CONTACT NAME (Not travelling with you) |  | CONTACT NO. / CELL NO. |  |

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| GENERAL HEALTH QUESTIONS |

1. Please rate your overall fitness level on a score of 1-5 where 5 = very fit, 3 = average fitness & 1 = unfit

Circle your rating

1 2 3 4 5

1. Do you suffer from any chronic ailments?

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| Diabetes | YES / NO | Cardiovascular disease | YES / NO | Hypertension | YES / NO |

YES / NO

1. Are you a smoker or have you recently quit smoking?
2. Are you?

|  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- |
| Under 65 years |  | 65 – 70 years old |  | 70 – 85 years old |  | 85+ years old |  |

1. Do you have any physical impairments? Please indicate:

|  |
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|  |

YES / NO

1. Have you travelled internationally in the last 30 days?

If yes:

1. Which country(s) have you visited?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date(s): \_\_\_\_\_\_\_\_\_\_\_\_\_\_
2. If SA Resident, which country did you return to SA from?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date (s): \_\_\_\_\_\_\_\_\_\_\_\_\_
3. In the last 14 days, to your knowledge, have you been in close contact with anyone who tested positive for COVID-19, or is in quarantine, or is awaiting a COVID-19 test result?

YES / NO

1. Are you awaiting test results of a COVID-19 test?

YES / NO

1. Do you have travel insurance which covers your medical and quarantine and isolation costs in the event you come into contact with COVID-19 positive people or contract COVID-19? (For international visitors only)

YES / NO

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| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| Guests Signature | |  | | | | Date | |  | | |
| TRIP & DAILY HEALTH | | | | | | | | | | |
|  | Day 1 | | Day 2 | Day 3 | Day 4 | | Day 5 | | Day 6 | Day 7 |
| Date: |  | |  |  |  | |  | |  |  |
| Staying at? |  | |  |  |  | |  | |  |  |
| Room number / Vehicle Registration |  | |  |  |  | |  | |  |  |
| Vehicle Seat no. if applicable |  | |  |  |  | |  | |  |  |
| Temperature arrival |  | |  |  |  | |  | |  |  |
| Staff Sign |  | |  |  |  | |  | |  |  |
| Temperature depart |  | |  |  |  | |  | |  |  |
| Staff Sign |  | |  |  |  | |  | |  |  |
| Flights taken (no’s) |  | |  |  |  | |  | |  |  |
| COVID-19 Symptoms? | | | | | | | | | | |
| Cough |  | |  |  |  | |  | |  |  |
| Sore throat |  | |  |  |  | |  | |  |  |
| Shortness of breath |  | |  |  |  | |  | |  |  |
| Cleared to check in (if applicable) |  | |  |  |  | |  | |  |  |
| COVID-19 Brief given |  | |  |  |  | |  | |  |  |
| Guest Signature |  | |  |  |  | |  | |  |  |

\*Minimum one daily temperature required