

# Covid-19 Risk Assessment

## Member Information

Name and Surname: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

E-mail Address: \_\_\_\_\_ Contact Number: \_\_\_\_\_

Company Name: \_\_\_\_\_

Residential Address/Suburb: \_\_\_\_\_

Transport to work: ☐ Car ☐ Public Transport

## Travel

Have you travelled locally in the past 14 days? ☐ Yes ☐ No

If yes, please specify: \_\_\_\_\_

Have you been to any gatherings (more than 10 people) either religious or social in the past 14 days? ☐ Yes ☐ No

If yes, please specify: \_\_\_\_\_

Have you been in contact with anyone who has tested positive with COVID-19? ☐ Yes ☐ No

If yes, name date of exposure: \_\_\_\_\_ Did you self quarantine? ☐ Yes ☐ No

## COVID-19 Symptoms

Have you experienced any of the below in the past 14 days?

Cough: ☐ Yes ☐ No

Shortness of breath: ☐ Yes ☐ No

Fever: ☐ Yes ☐ No

General body pains: ☐ Yes ☐ No

Sore throat: ☐ Yes ☐ No

Loss of taste: ☐ Yes ☐ No

Loss of smell: ☐ Yes ☐ No

## Health

Do you have any underlying medical conditions that could put you at risk if contracting COVID-19? ☐ Yes ☐ No

If yes, please specify: \_\_\_\_\_

Does anyone in your household have any underlying medical conditions? ☐ Yes ☐ No

If yes, please specify: \_\_\_\_\_

## Good Hygiene Practise

Do you understand the principal of social distancing? ☐ Yes ☐ No

Do you understand you need to wear a mask in public? ☐ Yes ☐ No

Do you practise safe hygiene practise, namely washing and sanitising hands regularly, cough and sneeze etiquette?

☐ Yes ☐ No

## Signature

I, \_\_\_\_\_  
(full name/s), hereby declare the above information is true and correct at the time of submission.

Date: \_\_\_\_\_

Signature:

Mkoma