COVID-19 - GUEST INFORMATION FORM

RIGHT OF CONVEYANCE OR ADMISSION RESERVED

We appreciate that we are asking for more detailed information than usual. This information is to ensure we can address appropriately any risks should you or one of our guests or 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 person 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.

GUEST DETAILS

NAME		**SURNAME**	
ID / PASSPORT NUMBER			
CONTACT TEL NUMBER - CELL			
EMAIL ADDRESS			
COUNTRY/PLACE/TOWN OF RESIDENCE			
EMERGENCY CONTACT NAME *(Not travelling with you)*		**& NUMBER**	

GENERAL HEALTH QUESTIONS

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

Circle your rating: 1 2 3 4 5

2 Do you suffer from any of the following chronic ailments?:

Diabetes	YES / NO
Cardiovascular disease	YES / NO
Hypertension	YES / NO

3 Are you a smoker or have recently quit smoking?

YES / NO

4 Are you?

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

5 Do you have any physical impairments? Please indicate:

6 Have you travelled internationally in the last 30 days? YES / NO

If yes:

a Which country(s) have you visited? Dates:

b If SA Resident, which country did you return to SA from? Dates:

7 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

8 Are you awaiting test results of a COVID-19 test? YES / NO

9 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

GUEST 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 signature							
*Temperature departure							
Staff signature							
Flights taken (no.s)							
COVID Symptoms?							
Cough	YES / NO	YES / NO	YES / NO	YES / NO	YES / NO	YES / NO	YES / NO
Sore throat	YES / NO	YES / NO	YES / NO	YES / NO	YES / NO	YES / NO	YES / NO
Shortness of breath	YES / NO	YES / NO	YES / NO	YES / NO	YES / NO	YES / NO	YES / NO
Cleared to Check-in (if applicable)							
COVID19 Briefing given							
Staff signature							
Guest Signature							

*Minimum one daily temperature required

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