COVID-19 SCREENING FORM

Name & Surname:	
Dept/class:	
Date:	
Have you been in contact with someone in the past 14 days that tested positive for Covid-19?	Y/N
Do you suffer from:	
Cough	
Sore throat	
Shortness of breath	
Difficulty breathing	
Body aches	
Weakness or Tiredness	
Loss of Smell/Taste	
Diarrhoea	
To be completed by the person screening:	
Wearing a mask:	
Temperature:	
Screened by:	
Comments:	

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DEUTSCHE INTERNATIONALE SCHULE JOHANNESBURG

PLEASE NOTE:

The DSJ resumes operation during the covid-19 pandemic, however we must conduct regular screening of all persons entering the school grounds to ensure their safety. Please advise any person in charge if you start to feel unwell during the day

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