COVID-19 Infection Screening Questionnaire

Dear Guests (Clients and non-Clients),

Do you or anyone accompanying you have any of the following symptoms?

Please tick Yes or No to each symptom, and answer the following questions?

Symptom	YES	NO
Fever		
Cough *(excluding asthma)*		
Sore Throat		
Difficulty breathing		
Loss of smell or taste		
Runny Nose *(excluding allergies)*		
	YES	NO
Have you or anyone accompanying you been in close contact with someone who has had COVID-19?		
	YES	NO
Have you or anyone accompanying you returned from overseas or interstate recently?		
	YES	NO
Have you or anyone accompanying you travelled to any known current "hot spots" in the past 14 days?		
	YES	NO
Have you or any of your family/group had a COVID-19 test and awaiting results?		

If you have answered **YES** to any of the above questions you are <u>not allowed</u> to enter the Royal Far West premises including Drummond House.

Please put on a face mask and exit the building and make your way to the nearest COVID-19 testing clinic.

Guests Name *(Please print)*: _____

Signature: _____

Date: __/__/____