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HEALTH QUESTIONARE: SCREENING FOR COVID-19

***THIS QUESTIONARE IS TO BE COMPLETED BY EACH MEMBER OF PUBLIC BEFORE ENTERING THE FACILITY**

Date:						
First name:	**Surname:**					
Date of Birth/age:	**Cell phone Number:**					
Sex:	**Male**		**Female**		**Other**	
Address:						

***Do you experience any of the following signs and/or symptoms?**
(Acute i.e. 7 days, respiratory illness with sudden onset of at least one of the following: -)

	Symptom				
a.	Fever		**Yes**		**No**
b.	Cough		**Yes**		**No**
c.	Shortness of breath		**Yes**		**No**
d.	Sore Throat		**Yes**		**No**
	OR				
e.	T° ≥ 38°C (**at the Facilities**)		**Yes**		**No**

NOTE: IF THE MEMBER OF PUBLIC ANSWERS NO TO ALL THE QUESTIONS, THE INTERVIEW ENDS.

***IF YES TO ANY OF THE QUESTIONS, REFUSE ENTRANCE.**