All participants and leaders must record the answers to the questions in the table below prior to the activity commencing.

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| --- | --- | --- | --- |
| Date: |  | Activity Leader: |  |
| Venue: |  | Activity Leader contact number: |  |
| Participant |  | Scanning questions |
| Name | Surname | Contact Number | Symptoms | Contact | Travel |
| Have you currently or in last 24 hours had a cough, shortness of breath or difficulty breathing? **(Yes/No)** | Have you currently or in last 24 hours had a fever, suffered from chills, or had muscle pains? (**Yes/No)** | Have you suffered from a headache, loss of taste or smell or sore throat? **(Yes/No)** | Have you had contact with a COVID 19 infectedPerson within the last 14 days? **(Yes/No)** | Have you travelled to a COVID 19 infected Area or Area or travelled internationally in the past 14 days? **(Yes/No)** |
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