Postal Address:

P.O Box 61538

Marshalltown

2107

Email: mashilo@mmcon.co.za

Tel: 084 430 1442

www.softballsouthafrica.co.za

Appendix 3 – Pre-Tournament Questionnaire/ Health Declaration Form

Date (dd/mm/yyyy)		
Full Name as shown in the passport and other ID	First Name:	Last Name:
ID or Passport	Number:	
Permanent address		
Telephone number		
E-mail address		
Countries that you visited or stayed in past 14 days		

History of exposure	YES	NO
Within the last 14 days, have you had contact with any person who has been tested positive for an infection with the COVID-19?		
Have you ever been admitted to or visited a hospital in the past month?		
If yes, please specify the reason for the admission or visit:		

Have you experienced any of the following symptoms during the past 14 days?					
Symptoms	YES	NO	Symptoms	YES	NO
* Fever			*Vomiting/Nausea		
*Cough			*Diarrhea		
Dyspnea			Skin hemorrhage		
Sore throat			Rash		
Chest Pain			Fatigue/Tiredness		
Conjunctivitis			Headache		
Myalgia			Loss of taste		
Chills			Loss of smell		
If you answered YES to any and are being treated already, please list which vaccines and/or biologicals are being used:					

NB: Please be aware that if you have answered YES to any of the above questions, you should stay at home, inform your Team Manager immediately and follow local public health guidelines.