South African Practical Shooting Association

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COVID-19 DECLARATION FORM

First Name:	
Last Name:	
Reason for visit:	
SAPSA Number:	
Residential Address:	
Cell number:	

Have you now, or in the past 48 hours, had any of the following flu-like symptoms?

Symptom	Yes	No
Fever	☐ Yes	☐ No
Shortness of Breath	☐ Yes	☐ No
Dry Cough	☐ Yes	☐ No
Sore throat	☐ Yes	☐ No
Chills	☐ Yes	☐ No
Vomiting	☐ Yes	☐ No
Diarrhea	☐ Yes	☐ No
Body Pains	☐ Yes	☐ No
Loss of smell and taste	☐ Yes	☐ No

Have you or any immediate family members travelled outside the borders of South Africa:

☐ Yes Name of Country/City: Date of arrival: Date of departure:	☐ No

Have you or any immediate family members come into close contact with a confirmed case of Coronavirus in the last 14 days?

☐ Yes If yes…Name of City/Country where contact took place	☐ No

I, ……………………………………………………………, declare that I honestly answered all questions and personal details provided is all true & correct. I also agree to adhere to all health and safety rules and will notify the club and match officials should I develop symptoms within 48 hours of attendance

Date: Signature: