Office of the Chief Justice
Free State Division of the High Courts, South Africa

COVID - 19
REGISTRATION & SCREENING FORM

Full Names	Reason/ Purpose	Contact Number(S)	Age	Temp

CHECKLIST	YES	NO
Do you have any flu symptoms such as headaches, running nose, sore throat, cough or fever?		
Do you have red eyes or shortness of breath?		
Do you have body aches?		
Do you have loss of smell or taste?		
Do you have nausea or vomiting?		
Do you have diarrhea?		
Do you have fatigue, or feeling weak?		
Have you been abroad?		
Has any member of your family, close relative or friends tested positive in the last 10 days?		

SIGNATURE	DATE
	_____/_____/2021