COVID-19 Health Screening Declaration Form

The information collected below is to facilitate the screening process as required by the Commonwealth Department of Health. In accordance with the Privacy Act 1988, the information is collected solely for the purpose of ensuring we comply with current legislation. Records will be safely and securely stored and destroyed when no longer required.

Please note, that when you are **not able** to meet these guidelines you will **not be able to participate or facilitate any events or programs organised by (ADD YOUR CLUB/CENTER NAME HERE).** We hope you understand that these measures are put in place to ensure the health and safety of our staff, volunteers and participants.

Name of person completing: _____

Please read the following and tick as applicable

	YES	NO
1. I have returned from a place outside Australia in the last 14 days		
2. I have been in contact with someone confirmed or suspected to have COVID-19 in the last 14 days		
3. I am currently unwell with any of the following: fever, symptoms of acute respiratory illness (sore throat, runny nose, cough, headache, shortness of breath), loss of sense of smell or taste, chills, muscle pain joint pain, diarrhoea, nausea/vomiting, or loss of appetite.		
4. I am currently in close contact caring for someone who is unwell		
5. I have been diagnosed with COVID-19		
6. I have been diagnosed with COVID-19 previously and have been given clearance from isolation (proof required)		
7. If requested I agree to have my temperature checked		
8. I agree to arrive prepared for the session and am prepared to leave immediately after its completion		
9. I agree to comply with current health guidelines and practice physical distancing during the session		
10. I agree to abide by and additional directions/instructions I am given by the Australian Sailing staff while I am facilitating or participating in the session and understand these are given in the interest of the safety of staff, volunteers and participants at The Boatshed.		

Signed by:_____ Date: _____ /____ /_____

Staff or Management to complete:

1. Proof of clearance if previously diagnosed with COVID-19 has been sighted and copy made. Yes No