# PERSONAL HEALTH CHECK INFORMATION FORM

|  |  |
| --- | --- |
| Name*(As shown on passport or ID card)* |  |
| National Federation |  |
| Permanent place of residence |  |
| Address during the event |  |
| Mobile Phone Number |  |
| E-mail address |  |
| Countries that you visited or stayed in during the last 14 days |  |
|  | **NO** | **YES** |
| Have you had any of the following symptoms during the last 14 days:* Cough
* Fever
* Sore throat
* Severe fatigue
* Aching muscles or joints
* Difficulty breathing
* Loss of taste or smell
* Headache
* Nausea/vomiting
* Diarrhoea
 |  |  |
| Have you been in contact with someone with a proven infection with Covid-19? |  |  |
| Have you been in quarantine during the last 14 days or told to self-isolate? |  |  |
| Have you tested positive to the PCR (Polymerase chain reaction) test during the last 14 days? |  |  |

SIGNATURE and DATE: