# PERSONAL HEALTH CHECK INFORMATION FORM

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| --- | --- | --- | --- |
| 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: