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 you visited or stayed in over the last 14 days			
		NO	YES
Have you had any of the following symptoms during the last 14 days: • Runny nose • Sneezing • Sore Throat • Severe Fatigue • Aching muscles or joints • Difficulty breathing • Loss of taste or smell • Headache • Cough • Fever • Nausea/Vomiting • Diarrhoea		○	○
Have you recently had contact with a proven Covid 19 positive individual?		○	○
Have you had to quarantine or been told to self isolate within the last 14 days?		○	○
Have you had a negative rapid antigen or PCR test **within 24h prior** to competition venue access?		○	○
Signature:	Date:		