

**Health Questionnaire: SCREENING FOR COVID-19**

*This questionnaire is to be completed by each person at the competition venue*

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| Do you experience any of the following signs and symptoms? Yes/No  | Covid-19 testing |
|  | Fever  | Cough  | Shortness of breath | Sore throat  | Loss of taste | Loss of smell | Have you tested positive for Covid-19 in the past 14 days? | Have you been in contact with someone who tested positive for Covid-19 in the past 14 days |  |
|  | Date | Name and Surname | Contact details(Cell phone no.)  | Date of birth/Age | Sex(Male/Female/Other) | Home address | Temporary address | **Yes/No** | **Yes/No** | **Yes/No** | **Yes/No** | **Yes/No** | **Yes/No** | **Yes/No** | **Yes/No** | **Temperature** |
| 1 |   |   |   |   |   |   |   |  |  |  |  |  |  |  |  |  |
| 2 |   |   |   |   |   |   |   |  |  |  |  |  |  |  |  |  |
| 3 |   |   |   |   |   |   |   |  |  |  |  |  |  |  |  |  |
| 4 |   |   |   |   |   |   |   |  |  |  |  |  |  |  |  |  |
| 5 |   |   |   |   |   |   |   |  |  |  |  |  |  |  |  |  |
| 6 |   |   |   |   |   |   |   |  |  |  |  |  |  |  |  |  |