

COVID-19 HEALTH DECLARATION FOR ATHLETE OR TEAM MEMBER

ATHLETE

First and last name

Social ID no

TEAM MEMBER

First and last name

Social ID no

1. Has somebody of your family had any encounters with someone who's COVID-19 positive in the last 14 days?

Yes when No

2. Do you have any of the symptoms listed below?

Yes No

- fever over 37,5 °C
- cough
- soar throat
- difficulty breathing, shortness of breath
- loss of taste and smell sensitivity
- muscle ache
- tiredness

3. Have you previously had a COVID-19 test with a POSITIVE answer?

Yes when No

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/signature/

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/date/