**PRE EVENT QUESTIONNAIRE**

**(Obligatory to fill in, print and take to Registration by every Athlete)**

|  |  |  |  |
| --- | --- | --- | --- |
| **Name as shown in the passport or other ID** |  | | |
| **Your permanent address (street/apartment/city/postal number/country)** |  | | |
| **Your address during the event** |  | | |
| **Your telephone number** |  | | |
| **Your e-mail address** |  | | |
| **Countries that you visited or stayed in last 14 days** |  | | |
| **QUESTION - Within the past 14 days, have you... YES NO** | | | |
| **Had close contact with anyone diagnosed as having Coronavirus disease COVID-19?** | |  |  |
| **Provided direct care for COVID-19 patients?** | |  |  |
| **Visited or stayed in a closed environment with any patient having Coronavirus disease COVID-19?** | |  |  |
| **Worked together in close proximity, or sharing the same classroom environment with COVID-19 patient?** | |  |  |
| **Travelled together with COVID-19 patient in any kind of conveyance?** | |  |  |
| **Lived in the same household as a COVID-19 patient?** | |  |  |
| **Been in quarantine?** | |  |  |
| **Tested positive to the swap PCR test?** | |  |  |
| **Experienced any of the following symptoms now and in the previous 14 days:** | |  |  |
| * **Fever** | |  |  |
| * **Cough** | |  |  |
| * **Fatigue** | |  |  |
| * **Dyspnea** | |  |  |
| * **Myalgia** | |  |  |
| * **Sore Throat** | |  |  |
| * **Conjunctivitis** | |  |  |
| * **Chest Pain** | |  |  |
| * **Congestion/Coryza** | |  |  |
| * **Headache** | |  |  |
| * **Chills** | |  |  |
| * **Nausea/Vomiting** | |  |  |
| * **Diarrhea** | |  |  |
| * **Anosmia/Dysgeusia** | |  |  |
| * **Chilblains/Pernio** | |  |  |

Date and Signature…………………………………………………………………………………………...