COVID-19 HEALTH QUESTIONNAIRE (*)

First Name _____ Last Name _____

National Federation/Club _____

Please, cross the proper:

Kickboxer		Referee/Judge		Other official	

Age Category _____ Kickboxing discipline _____

Email _____ Phone Number _____

Have you experienced any of the below symptoms in the last 14 days?

	YES	NO
Body Temperature ≥37.5°C		
Dry cough		
Nasal congestion		
Sore throat		
Difficult breathing		
Headache		
Conjunctivitis		
Muscle aches and pains		
Diarrhea or vomiting		
Loss of taste and/or smell		
Fatigue without a known cause		
Rash on the skin or discoloration of fingers or toes		

	YES	NO
Have you had a closed contact (within 1.5 meters for 15 minutes or more cumulatively over a 24-hour period) with an individual infected with the COVID-19 virus in the last 14 days?		

In addition, I confirm that in case I have had COVID-19, I have had a medical clearance before resuming training, stating that I am fit for competitive kickboxing.

DECLARATION: "I declare that, pursuant to Regulation (EU) 679/2016 (GDPR), I am aware that the data collected through this document will be processed for the purposes described in WAKO Privacy Notice and that I have taken vision of the latter pursuant to art.13 GDPR."

Date _____

_____
Signature of athlete (or parent/legal guardian if underage)

* *Hand in at the onsite registration*

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