CROATIAN KICKBOXIN GEDERATION

Organizing Committee
Health Committee

MEDICAL QUESTIONNAIRE
FOR SARS-COV-2 INFECTION RISK ASSESSMENT (COVID-19)

KICKBOXING CLUB: _____

Name i surname, year of birth: _____

Address: _____

Contact phone: _____

Contact e-mail address: _____

Measured body temperature during registration / control weighing: _____ °C

Please fill out legibly / Round up answers to the following questions:

1.	Have you in last 14 days stayed out of Croatia?	YES	NO
1.1.	If answer is YES, specify where:		
2.	Have you been in contact with a person who has been confirmed with COVID-19 infection in the last 14 days?	YES	NO
3.	Have you been in contact with a person who has been assigned a self-isolation measure in the last 14 days?	YES	NO
4.	Have you been assigned a self-isolation measure?	YES	NO
5.	Have you been taking painkillers, temperature lowering or antibiotics in the last 14 days?	YES	NO
5.1.	If the answer is YES, specify which medicine and when:		

6. Have you had any of the following symptoms in the last 14 days:

6.1.	High body temperature (37,2 °C or higher)	YES	NO
6.2.	Dry cough	YES	NO
6.3.	Breathing difficulties	YES	NO
6.4.	Sense of smell and taste loss	YES	NO
6.4.	General body weakness	YES	NO
6.5	Muscles and joints pain	YES	NO
6.6	Headache	YES	NO
6.7.	Sore throat	YES	NO

Place _____ Date and time: _____

Signature: _____

Note: *It is filled by each participant of European Cup, and the completed and signed form is submitted to the Competition - Registration Committee of the CKBF during the registration for competitors.*