**HEALTH INVESTIGATION QUESTIONNAIRE BEFORE THE COMPETITION FOR**

**PARTICIPANTS**

**Name and Surname** (competitor):\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Phone nr.**:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Place and date of competition**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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|  | **QUESTION (all questions refer to the past 14 days)** | **YES** | **NO** |
| 1. | Do you have a fever (above 37.5º C)? |  |  |
| 2. | Do you have a cold? |  |  |
| 3. | Do you cough? |  |  |
| 4. | Do you have a sore throat? |  |  |
| 5. | Do you have a changed taste or smell? |  |  |
| 6. | Do you have a feeling of shortness of breath or tightness in your chest? |  |  |
| 7. | Do you have muscle aches? |  |  |
| 8. | Do you have digestive problems (diarrhea or vomiting)? |  |  |
| 9. | Does anyone else have such problems at home or at work? |  |  |
| 10. | Did you perhaps have a positive smear on Covid-19? |  |  |
| 11. | Have you been in contact with a COVID-19 confirmed patient? |  |  |

**If you answered YES to any of the questions, before participating in the competition, first consult your personal doctor or clinic by phone.**

A fully completed questionnaire is a condition for participation in the competition and an integral part of the competition minutes.

By signing, I confirm the truth of all statements:

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|  | Signature of the participant of the competition |