

FIS Health Questionnaire

Name: _____

Nation: _____

Function (athlete, Coach, Service, etc.): _____

Date: _____

- Have you had any cold symptoms (cough, runny nose, sore throat, difficult breathing, loss of taste or smell) during the last 14 days?

Yes

No

- Have you had any of the following symptoms during the last 14 days?

- fever

- chest pain

- headache

- nausea / vomiting

- diarrhea

- none

- Have you been in contact with someone with a proven infection of COVID-19?

yes

no

- Have you been in quarantine during the last 14 days?

yes

no

- Have you tested positive to the PCR (Polymerase chain reaction) test during the last 14 days?

yes

no

Signature: _____