

Health-Check Questionnaire

Everyone	Last Name	
	First Name	
	Telephone Number	
	Email Address	
	Countries visited in last 14 days	
Group: <input type="checkbox"/> OC <input type="checkbox"/> World Rowing <input type="checkbox"/> Teams <input type="checkbox"/> Others. _____		
Club Name		
Address during event		
Within the past 14 days, have you...		
Had close contact with anyone diagnosed as having Coronavirus disease COVID-19?	<input type="checkbox"/> yes <input type="checkbox"/> no	
Provided direct care for COVID-19 patients?	<input type="checkbox"/> yes <input type="checkbox"/> no	
Visited or stayed in a closed environment with any patient having Coronavirus disease COVID-19?	<input type="checkbox"/> yes <input type="checkbox"/> no	
Worked together in close proximity, or sharing the same classroom environment with COVID-19 patient?	<input type="checkbox"/> yes <input type="checkbox"/> no	
Travelled together with COVID-19 patient in any kind of conveyance?	<input type="checkbox"/> yes <input type="checkbox"/> no	
Lived in the same household as a COVID-19 patient? <input type="checkbox"/> yes <input type="checkbox"/> no Been in quarantine?	<input type="checkbox"/> yes <input type="checkbox"/> no	
Tested positive to the swap PCR test?	<input type="checkbox"/> yes <input type="checkbox"/> no	
Experienced any of the following symptoms now and in the previous 14 days: Fever, Cough, Fatigue, Dyspnea, Myalgia, Sore Throat, Chest Pain, Congestion/Coryza, Headache, Chills, Nausea/Vomiting, Diarrhea, Anosmia/Dysgeusia, Chilblains/Pernio (please specify)	<input type="checkbox"/> yes <input type="checkbox"/> no	

- I confirm that I will agree and comply with the COVID Infection Prevention Plan of the Organizing Committee.**
- I am aware these regulations can only minimize the infection risk and neither the OC nor World Rowing can be made liable for any potential infection.**
- I consent to the Organizing Committee and World Rowing collecting and storing the provided data according to GDPR.**
- I confirm I am responsible for any costs related with regards to my potential infection (e.g. testing / hospitalization / hotel / hotel quarantine).**

Date . . .2021

Signature _____

The form has to be filled in on 23-25th August 2021