v.z.w. ALL BELGIUM KENDŌ FEDERATION a.s.b.l.

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Questionnaire

Mandatory form to be handed over to the organization of the event!

Surname / Name:
Address:
License Nr: Dojo:
Telephone Nr: e-mail:

1. Are you currently experiencing, or have you experienced in the past 14 days, any of the following symptoms?
   IMPORTANT SYMPTOMS
   - Fever (temperature higher than 38°C) Yes - No
   - Dry Cough Yes - No
   - Difficulty Breathing or high respiratory rate (> 20 / min) Yes - No
   - Anosmia (loss of the sense of smell) Yes - No
   - Ageusia (loss of taste function) Yes - No

   SECUNDARY SYMPTOMS
   - Sore throat Yes - No
   - Rhinorrhea ("runny nose") Yes - No
   - Chest pain Yes - No
   - Myalgia (pain in a muscle or group of muscles) Yes - No
   - change in general well-being or general fatigue Yes - No
   - Confusion (ideas mixing, disorientation) Yes - No
   - Headaches Yes - No
   - Diarrhea Yes - No
   - nausea or vomiting Yes - No
   - skin rash or frostbite/chapped fingers or hands Yes - No

2. Were you in close contact (eye to eye, less than 1m and/or for more than 15 minutes, without a mouth mask both for you and for the contact person) with a person who tested positive from COVID-19 in the past 14 days? Yes - No

Medical Staff ABKF – Dr. Marc Namèche

This document is strictly confidential and cannot be shared without written permission of the undersigned.

Date & Signature