Screenning Process for **“COVID 19**”

Name: -...............................................................................................................................................

ID :- ..............................................................................................................................................

School/Association/Company:…………………........................................................................................

Mobile Number :- .............................................................................................................................

Time of Play :- ………………………………………………………………………………………………………………………………

1. Do you have any symptoms of Fever, Headache, Cough or Cold?

Yes No

2.

 2.1 Did you or your family members consult a doctor within the last 60days?

Yes No

 2.2 If yes, reason

 ..............................................................................................................................................................................

3.

3.1 Did you or your family members travel out of of the country within the last 60days?

Yes No

 3.2 If yes, details

 ..............................................................................................................................................................................

4. Have you associate any person who had the Covid-19, within the last 60days?

Yes No

I hereby certify that the information I have provided above is true and accurate.

..................................................... ........................................................ Date Signature