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

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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

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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