**Covid Secure Questionnaire**

**Date**

**Session**

**Session Leader**

|  |  |  |
| --- | --- | --- |
| Please tick appropriate box | **Yes** | **No** |
| Do you have a fever or felt feverish in the last 14-21 days? |  |  |
| Are you having shortness of breath or other difficulties breathing? |  |  |
| Do you have a new continuous cough? |  |  |
| Does anyone in your household have a fever or new continuous cough |  |  |
| Do you have any flu like symptom such as headache, gastrointestinal upset, headache or fatigue? |  |  |
| Have you experienced recent loss of taste or smell? |  |  |
| Have you been in contact with someone suffering with Covid without protection of appropriate PPE |  |  |
| Have there been any changes in your health since you last completed your health questionnaire for the club that may affect your health and safety if you run in the current pandemic conditions? (If in any doubt then it is advisable to contact your GP or appropriate health professional). |  |  |

**I confirm that all the names below have answered No to all the above questions. Including the session leader.**

**Signed………………………………………………………………… (Session leader)**

**Names**