The purpose of this medical questionnaire is to ensure that you are medically fit to exercise. Please answer the following questions with a YES or NO. If you are not sure, answer YES. A positive response means that there may be a pre-existing condition that could affect your safety while exercising. If any of these items apply to you, we must request that you consult with a doctor.

1. **TESTED POSITIVE OR PRESUMPTIVELY POSITIVE WITH COVID-19 (THE NEW CORONAVIRUS OR– SARS-COV2) OR BEEN IDENTIFIED AS A POTENTIAL CARRIER OF THE CORONAVIRUS?**

   ☐YES ☐NO

2. **EXPERIENCED ANY SYMPTOMS COMMONLY ASSOCIATED WITH COVID-19 (FEVER; COUGH; FATIGUE OR MUSCLE PAIN; DIFFICULTY BREATHING; SORE THROAT; LUNG INFECTIONS; HEADACHE; LOSS OF TASTE; OR DIARRHEA)?**

   ☐YES ☐NO

3. **BEEN IN ANY LOCATION/SITE DECLARED AS HAZARDOUS WITH AND/OR POTENTIALLY INFECTIVE WITH THE NEW CORONAVIRUS BY A RECOGNISED HEALTH OR REGULATORY AUTHORITY?**

   ☐YES ☐NO

4. **BEEN IN DIRECT CONTACT WITH OR IN THE IMMEDIATE VICINITY OF ANY PERSON WHO TESTED POSITIVE WITH THE NEW CORONAVIRUS OR WHO WAS DIAGNOSED AS POSSIBLY BEING INFECTED BY THE NEW CORONAVIRUS?**

   ☐YES ☐NO

The information I have provided about my medical history is accurate to the best of my knowledge. I agree to accept responsibility for any omissions in disclosing my existing or past health conditions. I also commit to inform about any symptom that may arrive after having filled in this declaration and/or having come into contact with someone who has tested positive after signing the declaration.

Print Name & Contact Number

_____

Signature

_____

Date

_____