Attendee Health Declaration Form

Branch Hosting Event
Participant Name
Participant Phone
Participant Address
Participant Email
Event Name
Event Date

Do you have any of the following symptoms?

- [ ] Fever
- [ ] Runny Nose
- [ ] Cough
- [ ] Chills or Sweats
- [ ] Shortness of breath
- [ ] Shortness of breath
- [ ] Sore Throat

Have you returned from any overseas country in the past 14 days?
- [ ] Yes
- [ ] No

In the past 14 days, have you been in close contact with anyone who has been diagnosed with COVID-19?
- [ ] Yes
- [ ] No

If you ticked any of the above symptoms (fever, cough, shortness of breath, sore throat), or YES to any of the above questions:

- You are not allowed to attend or compete at this or any other ASHS Approved events.
- Contact a health care professional for advice.

I declare that the information that I have provided is true and correct.
- [ ] Yes

SIGNATURE
Signed:

By completing this questionnaire, I consent to abide by current COVID-19 safety guidelines implemented by the hosting ASHS Branch and consent to ASHS collecting and disclosing my personal information for the purpose of preventing or managing the risk and/or reality of COVID-19 at ASHS sanctioned events and in compliance with the Privacy Act 1988 (Cth) and ASHS Privacy Policy.