

## Covid-19 Participant Checklist

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Name: \_\_\_\_\_

Venue: \_\_\_\_\_

Date: \_\_\_\_\_

1. Have you experienced any of the following Covid-19 symptoms in the last 7 days?

A high temperature  
New, continuous cough  
Loss or change to your sense of smell

Yes	No

2. Have you tested positive for Covid-19 in the last 7 days, or are you awaiting results?

Yes	No

3. In the last 14 days has any member of your household suffered with any symptoms of coronavirus.

Yes	No

4. In the last 14 days have any members of your household tested positive for coronavirus or are they awaiting test results

Yes	No

5. In the last 14 days have any members of your household tested positive for coronavirus or are they awaiting test results
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Yes	No

6. In the last 14 days have you been in known contact with anyone with either confirmed or suspected Covid-19 or have you been contacted as part of the NHS Track and Trace system

Yes	No

7. Do you fall into the “clinically extremely vulnerable” category and/or have you been asked to “shield” by the government?

Yes	No

8. Do you consider yourself to be clinically vulnerable to Covid-19?

Yes	No

9. In the last 14 days have you or any members of your household been outside the UK?

Yes	No

SIGNED: \_\_\_\_\_

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