● Health Check Sheet ●

Team Name			
Name(name of representative)		Age	
Address			
Phone number			

(1) Today's body temperature. (Please circle either Yes or No)

Fever above 37.5℃	Yes	No

(2) Have you experienced any of the following in the last 2weeks ? (Please check the applicable boxes on this form)

1. Fever	☐Yes	☐No
2. Flu-like symptoms such as cough, sore throat, congestion or runny nose	☐Yes	☐No
3. Fatigue, shortness of breath or difficulty breathing	☐Yes	☐No
4. New loss of taste or smell	☐Yes	☐No
5. Muscle or body aches	☐Yes	☐No
6. You have had close contact with someone who has been diagnosed with COVID-19	☐Yes	☐No
7. You have had close contact with someone who has symptoms of COVID-19	☐Yes	☐No
8. You have traveled to any infected countries/areas or been in close contact with someone who has traveled to those countries/areas in the last 14 days	☐Yes	☐No