Declaration of Honour Form

National Federation: _____

Club (optional): _____

Name: _____

Date of Birth: _____

Have you noticed any of the following symptoms within the last 14 days?

- Body temperature of over 37,5°C: ☐ YES ☐ NO
- Dry cough: ☐ YES ☐ NO
- Sore throat: ☐ YES ☐ NO
- Shortness of breath: ☐ YES ☐ NO
- Vomiting and/or diarrhoea: ☐ YES ☐ NO
- Sudden onset of articular and/or muscle pain: ☐ YES ☐ NO
- Fatigue without known cause: ☐ YES ☐ NO
- Problems in taste and/or smell: ☐ YES ☐ NO

Were you in the last 14 days in close contact with someone with declared Covid19 infection?

☐ YES ☐ NO

☐ I understand that participation is only possible in case all questions above are answered with "NO".

☐ I have answered all questions truthfully and understand that any violation against these guidelines will be subject to disciplinary action, even legal consequences might be faced.

☐ I DECLARE that I shall at all times abide by any instructions given to me by the Local Organizing Committee or any EJU official or other Public Health official in connection with the prevention of disease. I understand that restrictions may be changed due to necessity or to observe local laws on public health, and in case any such change of restrictions should affect my participation, I waive all rights for damages or other compensation.

Signature: ....

Print name: ....

Date: ....

Team Covid-19 Manager Athlete/parent*

*Consenting person: parent, caretaker, authorized person to sign a consent on behalf of the minor born 2003, 2004, 2005.