Access to the facilities is restricted and maximum cooperation is required from everyone in order to ensure optimal safety for all participants.

You are therefore requested to answer the following questions.

# PERSONAL DETAILS

Surname Date of birth Town/city of residence Phone number

Name Place of birth Street House no. / Email

As the parent of (Name and Surname):

# In the past 14 days, with regard to your child:

* has he/she had close contact\* or lived with a person with a suspected or confirmed diagnosis of a COVID-19 infection?
* has he/she had close contact\* with one or more persons with a fever (at home, office, work, etc.)?
* has he/she had close contact\* with one or more persons with symptoms associated with COVID-19 (at home, office, work, etc.)?
* has he/she been ordered to isolate at home due to COVID-19?
* is he/she waiting to have a COVID-19 swab or receive the results of a COVID-19 swab?
* has a family member, cohabitant, or person you see frequently died unexpectedly after a confirmed or suspected infection with COVID-19?

# \* Close contact with COVID-19 is defined as any that in the past 14 days has involved:

* direct physical contact with an individual (e.g. shaking hands);
* an unprotected direct contact with another individual's secretions (e.g. touching used paper handkerchiefs with bare hands);
* direct (face-to-face) contact with another individual, at a distance of less than 1 metre and for longer than 15 minutes;
* being in a closed environment (e.g. living room, meeting room, waiting room), with another individual, for at least 15 minutes, at a distance of less than 1 metre.
* contacts occurring in the two days prior to the onset of symptoms and subsequently up to the time of diagnosis and isolation.

Does your child have any of the following symptoms?

* fever (temperature ≥37.5°C) - this will also be checked at the point of entry to the facility
* cough
* fatigue
* generalized muscle aches
* headache
* common cold
* sore throat
* shortness of breath
* abdominal pain
* conjunctivitis
* diarrhoea
* vomiting
* arrhythmia (tachyarrhythmia or bradyarrhythmia) or syncopal episodes
* anosmia (altered sense of smell)
* dysgeusia (altered sense of taste)

*This information will be retained in the facility for at least 14 days and made available to the competent health authorities if requested. This form will be retained in the facility in accordance with current regulations governing privacy and a certified copy may be requested from the facility's management.*

*Aware of the criminal liability under Art.76 of Italian Presidential Decree no. 445 of 28 December 2000 for making false statements or declarations, I declare that the information provided herein is true and that I have read and comply with the visitor regulations.*

Date Signature of parent

***Section to be completed by the organizers***

**On the basis of the assessment carried out by the personnel in charge and with the favourable opinion of the COVID MANAGER, access to the facility is granted**

❏ YES ❏ NO

# Endorsed by (the COVID MANAGER or his representative)

Name and surname Signature

# STAMP AND SIGNATURE OF COVID MANAGER