



This document should be returned to Miss Keogh/Brendon prior to training.

Date:

Team/Section:

Name:

1. Do you believe you may currently have COVID-19? YES ___ NO ___

2. Have you had any of the following symptoms of COVID-19 in the past 14 days?

- High temperature (over 37.5°C) YES ___ NO ___
- Loss of sense of smell and/or taste YES ___ NO ___
- New continuous cough YES ___ NO ___
- New unexplained shortness of breath YES ___ NO ___

If you have answered YES to any of these questions above, you should stay at home and contact your GP by phone for further advice. If you have answered NO to all the above questions, you may train or play with your team on the date specified above.

Please sign this form to confirm that the details above are true to the best of your knowledge and confirm that you understand the risks involved in participation, are participating on a voluntary basis and that you may opt-out at any time.

Signed:* _____

*(For underage players, this document should be signed by a Parent or Guardian)

Please provide your contact details in the event contact tracing is required:

Phone:

Email:

Address:

Please follow all Hockey Ireland Return to Play Protocol when travelling to and from the ground and when partaking in training sessions.