

## Screening form

<b>Name:</b>	
<b>Unique nr:</b>	
<b>Symptom check:</b>	
	<b>Yes/No</b>
Sore throat	
Cough	
Shortness of breath	
Loss of taste/smell	
Fever	
Close contact with someone with Covid-19 in last 14 days	
Temperature (will be measured at pool)	
<b>Signature:</b>	