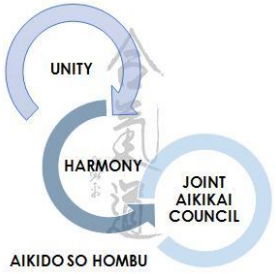
STUDENT INDEMNITY FORM



This form must be used to ensure that you are free from Covid-19 symptoms and pose a limited risk to others. Once completed please sign and date the form and send an e-version or give a paper copy to the dojo member responsible for registration.

NAME			
eMAIL		PHONE	
Last practice date			

VACCINATION RECORD	1st Vaccination Date	2nd Vaccination Date

Are you currently diagnosed with or believe you may have Covid-19?	YES	NO

Do you currently display any of the following symptoms?

	YES	NO
High Temperature (fever)		
A new or continuous cough		
Loss or change to your sense of taste or smell		
New unexplained shortness of breath		

Have you been in contact with a confirmed or suspected Covid-19 case in the last 10 days?	YES	NO	MAYBE

If you have answered YES to any of these questions you should stay at home, inform your dojo and seek medical advice.

Signature (written,typed,electronic)	

DATE	