



APPENDIX A

MEDICAL EXAMINATION FORM - COVID-19

<u>Last name</u>	
<u>First name</u>	
<u>Date of birth</u>	

Private and confidential

I confirm that I have conducted an examination on [insert individual's name] to assess whether or not he/she displays or reports any symptoms of COVID-19. The examination did not include the use a SARS CoV2 genetic material test (PCR or LAMP) or any antibody virus test.

I confirm that this individual **does/does not*** display or report any symptoms of COVID-19.

[Note – this form will need to be checked for compliance with local legislation around release of medical information]

*DELETE AS APPROPRIATE

Signed: _____

Name of Doctor:

Address of Doctor:

Doctor's contact details (email address and phone number):

Date:

Signed: _____

Name of individual:

Date:

By signing this examination form, I consent to my Doctor disclosing to World Athletics this examination form and whether I do or do not display any symptoms of COVID-19. Accordingly, I have signed the attached Medical Information Release Form. I confirm have read and understood the Medical Clearance Protocol Privacy Policy ('Privacy Policy') and that this form and the Medical Information Release Form will both be disclosed to third parties (as referenced in the Privacy Policy) for the purposes of deciding whether or not I pose a risk to public health in order to issue my accreditation to the World Athletics Half Marathon Championships Gdynia, Poland 2020. I also acknowledge that the Medical Clearance Protocol is subject to local legislation, regulations, and local government and public health authorities' guidance to safeguarding against the COVID-19 pandemic generally and the health and safety of all attendees at the event.