Team \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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| No. | Name, Surname | Temperature | Signature |
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“Team Bubble” Leader Signature\* \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Date \_\_\_\_\_\_\_\_\_

\*Each participant confirms with his/her signature that he/she does not have any of the symptoms listed below:

Fever / cough / sore throat / shortness of breath

Sudden loss or severe change in your sense of taste or smell

Diarrhea / nausea or vomiting / abdominal pain

Conjunctivitis / red or itchy eyes