COVID-19 Daily Pre-screening Questions

Name of Athlete: ____________________________ Date: ________________

Parent/Guardian Cell: ____________________________ Sport: ________________

Are you experiencing any of the following symptoms? Please Circle One

1. Fever(?: 100.4°F) YES NO

2. Cough or shortness of breath YES NO

3. Sore Throat YES NO

4. Chills YES NO

5. Muscle aches or rigors YES NO

6. Headache YES NO

7. New loss of taste or smell YES NO

8. Abdominal pain, nausea, vomiting or diarrhea YES NO

Have you had close contact with someone who is currently sick? YES NO

Have you been diagnosed with COVID-19 in the past three weeks or have Reason to believe you have COVID-19? YES NO

Have you traveled or had close contact with anyone who has traveled Internationally in the last 14 days? YES NO

Athlete's temperature reading at beginning of practice/game:

__________________________

Athlete's temperature recorded by:

__________________________

To participate in practice and games, each athlete must complete this form daily before every workout.