West Essex JR Field Hockey
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.