COVID Daily Sign-In Sheet

Name: ________________________________ **Date:** _____________

Temperature: ____________

Please check off yes or no for the following questions:

Now, or compared to the last time you answered the question, do you have any of the following, even if it is mild?

Cough	**Yes___ No___**
Shortness of breath	**Yes___ No___**
Chest pain	**Yes___ No___**
Feeling feverish, chills	**Yes___ No___**
Muscle pain	**Yes___ No___**
New loss of smell or taste	**Yes___ No___**
Gastrointestinal symptoms (nausea, vomiting and or diarrhea)	**Yes___ No___**
Sinus or cold-like symptoms headache, congestion, runny nose, sore throat	**Yes___ No___**
Has anyone in your household or any close contact had any of the above symptoms	**Yes___ No___**
Has anyone in your household or any close contact been diagnosed with COVID-19	**Yes___ No___**

Have you been to another out of state travel hockey event/practice/camp within the past two weeks

Yes____No___