COVID-19
Daily Pre-screening

MUST BE TURNED IN PRIOR TO ENTERING PRACTICE/GAME AREA

Date: _____ **Name of Athlete:** _____

Parent/Guardian Name/Cell: _____

Parent/Guardian Signature_____

1) **TEMPERATURE VERIFICATION (must be 100°F or under)**
If temperature is not recorded and initialed by parent we will take temperature

_____ Recorded by parent/guardian - please initial_____

_____ Recorded at check-in (must be 100°F or under)

2) **SYMPTOMS - Is athlete experiencing any symptoms below?**

____ Cough or shortness of breath	____ Breathing difficulty
____ Congestion or runny nose	____ Fever/chills
____ Body/muscle aches or fatigue	____ Headache or sore throat
____ New loss of taste or smell	____ Abdominal pain
____ Nausea or vomiting	____ Diarrhea

3) **CLOSE CONTACT WITH ANYONE WHO IS SICK?** Has athlete had close contact with someone who is currently sick?
_____ **No** _____ **Yes**

4) **COVID DIAGNOSES IN HOUSEHOLD? Has athlete, or a household member, been diagnosed with COVID-19 in the past three weeks ?**
_____ **No** _____ **Yes**

5) **ANY TRAVEL OUT OF STATE? Has athlete traveled, or had close contact, with anyone who has traveled out of state in the last 14 days?**
_____ **No** _____ **Yes**

6) **TRAVEL OUT OF COUNTRY Has athlete traveled, or had close contact, with anyone who has traveled internationally in the last 14 days?**
_____ **No** _____ **Yes**