Covid 19 Screening

Date_____

Player Name_____

Player Date of Birth_____

Parent Signature_____

Parent Name Printed_____

Check off all areas that apply

1. Review the following for the player.

Have any of the following symptoms appeared within the last 7 days:

☐Dry, persistent cough ☐Shortness of breath or difficulty breathing

☐Fever > 100.4°F ☐Gastrointestinal symptoms (diarrhea or vomiting)

☐Sore throat ☐Sudden loss of sense of taste and/or smell

☐Headache ☐Body aches

2. Has the player recently been tested for COVID-19 and is waiting for results to return?

☐Yes ☐No

3. Has the player recently been clinically diagnosed or has lab confirmation for COVID-19? (within the last 14 days)

☐Yes ☐No

4. Has the player been exposed to a household member that has lab confirmed COVID-19?

☐Yes ☐No

5. Has the player been on a cruise ship or been around any individual who has traveled on a cruise ship on the last 30 days?

☐Yes ☐No