Coronavirus Screening: Symptom Self-Assessment

Name: ______________________________

Date: ______________________________

Parent Name: ______________________________

Parent Signature:
(Player Signature if 18+) ______________________________

In the past 10 days have you had (check all that apply):

☐ Fever (100.4 or higher) or chills	☐ Cough	☐ New onset headache
☐ Sore throat	☐ Unexplained muscle ache	☐ New loss of taste or smell
☐ Nausea or vomiting	☐ Diarrhea	☐ None of these

Do you have severe shortness of breath or difficulty breathing?

☐ Yes ☐ No

Have you been diagnosed with coronavirus (COVID-19) within the past 10 days?

☐ Yes ☐ No

In the past 14 days, have you been within 6 feet for more than 15 minutes of someone with suspected or confirmed coronavirus (COVID-19)?

☐ Yes ☐ No

This form must be completed and submitted to your coach before each practice and game day, or you will be ineligible to play.