2020 COVID-19 SPORTS SCREENING

Please hand this to the Game Manager upon arrival

DATE 9/30/2020

FIRST NAME _____

LAST NAME _____

Date _____

Sport _____

Please indicate, by circling, if you have experienced any of the following symptoms in the past 48 hours:

- Fever or chills
- Cough
- Shortness of breath or difficulty breathing
- Fatigue
- Muscle or body aches
- Headache
- New loss of taste or smell
- Sore throat
- Congestion or runny nose
- Diarrhea

YES _____ NO _____

Within the past 14 days, have you had these types of contact with someone with a lab-confirmed case of COVID-19 while you were not both wearing masks or, when touching shared items, you were not wearing gloves?

CHECK ALL THAT APPLY.

- ○ Shared a home
- ○ Been within 6 feet of each other for at least five minutes
- ○ Been sneezed on or coughed on
- ○ Shared eating or drinking utensils or other items
- ○ Hugged or kissed
- ○ None of the above

I certify that the responses I have made above are accurate to the best of my recollection.

Signature _____