COVID/19 SCREEN FORM

Name (First, Middle, Last) _____
Please Print Legibly

Age * _____
Age is required

Gender _____ Primary Cell Number _____

Email Address _____

Team or team you are a guest of: _____

Symptom Check Information (Circle appropriate answer)

1. Temperature checked
   Fever* Yes No

2. Chills* Yes No

3. Cough* Yes No

4. Difficulty breathing/Shortness of breath* Yes No

5. Sore throat* Yes No

6. Headache* Yes No

7. Body aches* Yes No

8. Vomiting* Yes No

9. Diarrhea* Yes No

10. Have you been in contact with someone who had symptoms of COVID-19 but was not tested?*

Yes No Not Sure

11. Have you been in contact with someone who tested positive for COVID-19?*

Yes No Not Sure

I certify this information is correct.

_____ Date: _____
Signature