COVID-19 Daily Screening Questions

Name of Student: __________________________________________ Date: ____________________

Parent/Guardian Cell: ___________________________________ Sport: ____________________

Are you experiencing any of the following symptoms? Please Circle One

1. Fever (≥ 100.4°F) YES NO
2. Cough or shortness of breath YES NO
3. Sore Throat YES NO
4. Chills YES NO
5. Muscle aches or rigors YES NO
6. Headache YES NO
7. New loss of taste or smell YES NO
8. Abdominal pain, nausea, vomiting or diarrhea YES NO

Have you had close contact with someone who is currently sick? YES NO

Have you been diagnosed with COVID-19 in the past three weeks or have reason to believe you have COVID-19? YES NO

Have you traveled or had close contact with anyone who has traveled internationally in the last 14 days? YES NO

If you took your temperature this morning, what was the reading? _________________________

To participate in workouts during the summer recess period, each student must complete this form daily before every workout. This is a recommended template for the COVID-19 pre-screening questions. Districts can determine the best means (electronic or paper) and platform (Survey Monkey, Microsoft Teams, Google Docs etc.) to administer the screening questions. Screening questionnaires must be completed prior to arriving on school grounds.