

Participant Health Screening Questionnaire

(If it is determined you falsify any information on this form your child will be expelled from the league)

Participant Name -- please print

Event (ie boys 56 Raptors Game)

Please answer the questions below truthfully. This is one of the ways in which we can decrease the risk and minimize the spread of covid-19. Your teammates, coaches, parents and the community are depending on you to be honest. If you are currently sick, have had any of the symptoms listed below or have been in contact with someone who has covid-19 please refrain from coming to the gym.

Number	Question	No	Yes - include explanation
1	Have you experienced a fever during the last three (3) days???		
2	Have you experienced any unusual type of muscle aches during the last three (3) days???		
3	Do you have a cough, shortness of breath, or a sore throat???		
4	Are you experiencing gastrointestinal symptoms such as diarrhea, nausea or vomiting???		
5	Do you have a runny nose, stuffy nose or have you experienced loss of smell or taste???		
6	Have you traveled outside the DC, Maryland, Virginia or West Virginia area???. You must quarantine for ten (10) days from the date of travel. Seven (7) days if you produce a negative covid-19 test.		
7	Have you come in contact with anyone having a confirmed case of Covid-19???. You must quarantine for ten days (10) from date of last contact. Seven (7) days if you produce a negative covid-19 test.		
8	Have you come in contact with anyone who is suffering from any type of respiratory illness???. You must quarantine for ten (10) days from date of last contact. Seven (7) days if you produce a negative covid-19 test.		

Please print name (adult family member name)

Date



Signature