COVID SYMPTOM CHECK

TEAM _____

NAME: _____

Date of Practice you are attending: _____

Are you experiencing any of the following symptoms?

- **Loss of taste or smell**
- **Fever**
- **Sore Throat**
- **Cough or shortness of breath**
- **Chills**
- **Headache**
- **Muscle Aches not associated with physical exercise**
- **NONE of the ABOVE**

Within the last 14 days, have you had close contact with someone who is suspected or confirmed having COVID-19? _____ YES _____ NO

In the last 14 days, have you travelled internationally? _____ YES _____ NO

Are you or a member of your family currently waiting on the results of a COVID test? ____ YES ____ NO

(If you have experienced any symptom or answered yes to any question, you are NOT permitted to attend the practice or game.)