FRANKLIN REGIONAL YOUTH LACROSSE (FRYLAX)

COVID-19 Screening Questionnaire

IMPORTANT: If you answer **YES** to **ANY** questions on this questionnaire or have a temperature above 100.4° F (38° C), do **NOT** report for practice. Contact your coach immediately to discuss your concerns.

Have you, or anyone you have been in close (less than 6 feet), prolonged contact (more than 2-3 minutes) with, had any of the following symptoms in the last seven (7) days: ○ 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 ○ Nausea or vomiting ○ Diarrhea ○ Other flu-like symptoms	☐ **YES**	☐ **NO**
Have you been taking medication for a fever?	☐ **YES**	☐ **NO**
Have you recently (within the past 10 days) traveled outside of our local area or the US?	☐ **YES**	☐ **NO**
Have you been in close contact (within 6 feet) with anyone diagnosed with COVID-19, or anyone who has been quarantined for COVID-19?	☐ **YES**	☐ **NO**
Have you been medically directed to self-quarantine due to possible exposure to COVID-19?	☐ **YES**	☐ **NO**

_____
Player Name

_____ _____
Parent/Guardian Name *Relation*

_____ _____
Parent/Guardian Signature *Date*