HEALTH SCREENING QUESTIONNAIRE

Form 2020.C19
Revision: 01.03
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Participant: _____ Facility: _____

Activity Date: _____ Coach: _____

Temperature immediately prior to activity: _____ Cell number of person to contact during activity: _____

Section 1:

Player Health and Wellness Checklist	YES	NO	If yes, pease provide additional Information
Are you currently experiencing any of the following symptoms or combination of symptoms?			
• Cough	☐	☐	
• Shortness of Breath	☐	☐	
Or at least two of these symptoms:			
• Fever (100.4 or higher)	☐	☐	
• Chills	☐	☐	
• Repeated Shaking and Chills	☐	☐	
• Muscle Pain	☐	☐	
• Headache	☐	☐	
• Sore Throat	☐	☐	
• New Loss of Taste/Smell	☐	☐	
Are you currently waiting for COVID-19 test results?	☐	☐	
In the past 14 days, have you tested positive for COVID-19?	☐	☐	

Section 2:

Social Distancing & Exposure	YES	NO	If yes, please provide additional Information
In the past 14 days, have you self-quarantined or self-isolated? If so, for how many days and why?	☐	☐	
In the past 14 days, have you been exposed to anyone currently waiting for an active virus COVID-19 test results?	☐	☐	
Have you been exposed to anyone who has tested positive for COVID-19 in the past 14 days?	☐	☐	
In the past 14 days, have you been exposed to anyone with any of the following symptoms or combination of symptoms?			
• Cough	☐	☐	
• Shortness of Breath	☐	☐	
Or at least two of these symptoms:			
• Fever (100.4 or higher)	☐	☐	
• Chills	☐	☐	
• Repeated Shaking and Chills	☐	☐	
• Muscle Pain	☐	☐	
• Headache	☐	☐	
• Sore Throat	☐	☐	
• New Loss of Taste/Smell	☐	☐	
Have you or anyone in your household traveled outside the state in the past 14 days?	☐	☐	

Additional information

League Use Only

Notes: