Sparta Youth Football

DAILY COVID-19 Questionnaire

Name of Player: ____ 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
9. Have you had close contact with someone who is currently sick? YES NO
10. Have you been diagnosed with COVID-19 in the past three weeks or have reason to believe you have COVID-19? YES NO
11. Have you traveled or had close contact with anyone who has traveled internationally or to a restricted state in the last 14 days? YES NO
12. If you took your temperature this morning, what was the reading?

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To participate each player must complete this form daily before every practice and game.

Parent/Guardian Signature: ____________________________________