COVID-19 ATHLETE/COACH MONITORING FORM

Team: _____ Date: _____

Please answer Y (yes) or N (no) for each column. Anyone answering yes will not be allowed in the arena.

Player/Coach Name	Time	Sore Throat	Cough	Chills	Body Ache	Shortness of Breath	Loss of Taste	Loss of Smell	Fever at or greater than 100.4°	Contact with anyone testing positive for COVID-19 in last 14 days	Answer NO to all questions (place a √)

Team Representative Signature: _____ Tournament Official Signature: _____

Completed form must be submitted prior to the team entering the rink.