Central Florida Elite Covid-19 Screening Questionnaire

THIS FORM MUST BE COMPLETED AND RETURNED PRIOR TO PARTICIPATION IN EACH AND EVERY WORKOUT/TRYOUT/PRACTICE WITH CENTRAL FLORIDA ELITE

Player Last Name	Player First Name	Date

Emergency Contact	Emergency Contact Phone Number

- **Have you or a family member been exposed to COVID-19?** YES ☐ NO ☐
- **Have you experienced a fever within the last 48 hours?** YES ☐ NO ☐
- **Have you travelled outside of the state OR country within the last 14 days?** YES ☐ NO ☐

If so where? _____

- **Have you been diagnosed with COVID-19 within the last 14 days?** YES ☐ NO ☐

Have you experienced any of the following symptoms within the last 24 hours (please check all that apply)

❒ Shortness of Breath, Difficulty Breathing

❒ Consistent Cough

❒ Sore Throat

❒ Runny Nose/Nasal Congestion

❒ Nausea, Vomiting or Diarrhea

❒ Loss of sense of Smell or Taste

❒ Dizziness or Fatigue

❒ Chills/Severe Headache

I attest by checking the box below that I am not currently experiencing any COVID-19 Symptoms and have not been directly exposed to anyone that has been diagnosed with COVID-19. I am not currently participating in required quarantine.

❒ _____ **(Player Initials)**