

Johnson City Futbol Club
Box 573
Johnson City, TN 37605
423-979-5819



COVID-19 Pre-Participation Screening

Training Date: _____ Team: _____

Player Name: _____

1. Your temperature today is: _____

Please answer **Yes or No** to the following questions.

2. Have you experienced any of the following symptoms in the last 14 days?

Cough	Shortness of Breath	Sore Throat	Chills
Headache	Vomiting	Diarrhea	Difficulty Breathing

3. Have you received a positive COVID-19 test result in the last 14 days?

4. Have you been in close contact (within 6 feet for greater than 15 minutes) with someone who tested positive for COVID-19 in the last 14 days?

5. Do you have loss of taste or smell?

Parent/Guardian Name: _____

Parent/Guardian Signature: _____

If your player answered yes to any question, they may not participate in today's training session.

Stay apart as much as possible when not playing. Mask up if distancing cannot be maintained when not active. Have Fun!