2020 COVID-19 SCREENING QUESTIONNAIRE

1. Have you experienced a fever of 100.4˚F or greater in the past 10 days?

   YES ____ (must return home) NO ____

2. Have you received a positive result from a COVID-19 test within the past 14 days?

   YES ____ (must return home) NO ____

3. Have you been in contact with anyone while they had COVID-19 or symptoms of COVID-19 in the past 14 days?

   YES ____ (must return home) NO ____

4. Have you experienced any of the following symptoms within the past 14 days? Check all that apply.
   - ❏ Cough
   - ❏ Shortness of Breath
   - ❏ Sore Throat
   - ❏ Runny Nose
   - ❏ None of the above

PLAYER / VOLUNTEER (print) ______________________________

SIGNATURE IF PERSON IS ADULT ______________________________

IF MINOR, NAME OF PARENT / GUARDIAN (print) ______________________________

SIGNATURE OF PARENT / GUARDIAN ______________________________

TODAY'S DATE ______ / _____ / _____