COVID-19 Athlete and Parent Questionaire Form

NAME _____

Circle Yes or No to each of the questions below.

Have you had a temperature of 100.4 or higher over the last 72 hours?	YES	NO
Have you had a sore throat over the last 72 hours?	YES	NO
Have you experienced an unusual shortness of breath and/or difficulty breathing in the last 72 hours?	YES	NO
Have you experienced repeated chills with shaking anytime in the last 72 hours?	YES	NO
Have you experienced repeated headaches over the course of the last 72 hours?	YES	NO
Have you had any close contact with anyone who has tested positive for COVID 19 within the last two weeks?	YES	NO