COVID-19 Health Screening Form (Youth Athletics)

Date

Participant's Name

Parent/Guardian Name

Team/Organization

Contact Number

Health Screening Questions

1. Has the participant experienced any of the following symptoms in the past 24 hours? (Fever, cough, shortness of breath, sore throat, loss of taste or smell, nausea/vomiting, diarrhea, chills, muscle aches, headache)

Yes No

2. Has the participant been in close contact with anyone who has tested positive for COVID-19 or is awaiting test results?

Yes No

3. Has the participant tested positive for COVID-19 in the past 10 days?

Yes No

4. Has the participant traveled internationally or out of state in the last 14 days?

Yes No

Parent/Guardian Signature

Signature

Date