DAILY ATHLETE SCREENING FORM

Student Name: _____ Date: _____

Sport/Team: _____

Symptoms of COVID-19 Checklist (Check or circle Yes or No for each question)

Do you have a temperature over 100.3 degrees?	No	Yes
Do you have the chills?	No	Yes
Do you have a fever?	No	Yes
Do you have a cough?	No	Yes
Do you have a headache?	No	Yes
Do you have loss of taste or smell?	No	Yes
Do you have a sore throat?	No	Yes
Do you have diarrhea?	No	Yes
Do you have muscle pain?	No	Yes
Have you been vomiting?	No	Yes
Do you have shortness of breath?	No	Yes
Have you been in contact with anyone infected with COVID-19 or suspected of being infected with COVID-19?	No	Yes

If you have been in close contact with someone who has or is suspected to have COVID-19, or you have checked YES to any of the above questions it is important for you to stay home, separate yourself from others, and monitor your health. Please visit County of Los Angeles Public Health's quarantine and isolation recommendations LAC | DPH | COVID-19 Isolation (Patient Information)

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