



| | |
|---|---|
| Date | |
| Time | |
| First Name | |
| Last Name | |
| Division | |
| Team | |
| Car # | |
| | |
| Temperature | |

Have you received a lab confirmed dignosis of COVID-19?

| | |
|---|---|
| | Yes |
| | No |
| | If so, when? |

Are you experiencing any of the following:

| | |
|---|---|
| | Fever in past 3 days |
| | Cough |
| | Sore Throat |
| | Chills |
| | Runny nose or nasal congestion |
| | Shortness of breath, difficulty breathing, wheezing |
| | Headache |
| | Muscle pain/body aches |
| | Fatigue |
| | Diarrhea |
| | New loss of taste or smell |
| | ***NONE OF THE ABOVE*** |

Do you reside with anyone experiencing any of the following:

| | |
|---|---|
| | Fever in past 3 days |
| | Cough |
| | Sore Throat |
| | Chills |
| | Runny nose or nasal congestion |
| | Shortness of breath, difficulty breathing, wheezing |
| | Headache |
| | Muscle pain/body aches |
| | Fatigue |
| | Diarrhea |
| | New loss of taste or smell |
| | ***NONE OF THE ABOVE*** |

I certify that the information submitted in this screening tool is true and accurate to the best of my knowledge.

_____

Signature

_____

Responsible Adult Signature if participant is a Minor