COVID-19 Athlete / Coach Monitoring Form

Sport: ____________________ **Date:** ______________ **Person Responsible for Screening:** ____________________________

Name	Time	Circle Yes / No Below										Temperature	Further action needed? (yes/no)	Additional Comments
		Fever		Cough		Sore Throat		Shortness of Breath		Close contact or cared for someone w/ COVID-19				
		YES	NO	YES	NO	YES	NO	YES	NO	YES	NO			
		YES	NO	YES	NO	YES	NO	YES	NO	YES	NO			
		YES	NO	YES	NO	YES	NO	YES	NO	YES	NO			
		YES	NO	YES	NO	YES	NO	YES	NO	YES	NO			
		YES	NO	YES	NO	YES	NO	YES	NO	YES	NO			
		YES	NO	YES	NO	YES	NO	YES	NO	YES	NO			
		YES	NO	YES	NO	YES	NO	YES	NO	YES	NO			
		YES	NO	YES	NO	YES	NO	YES	NO	YES	NO			
		YES	NO	YES	NO	YES	NO	YES	NO	YES	NO			
		YES	NO	YES	NO	YES	NO	YES	NO	YES	NO			
		YES	NO	YES	NO	YES	NO	YES	NO	YES	NO			

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