COVID-19 TEMPERATURE CHECK AND SYMPTOM SCREENING

This form should be completed and brought to the meet by all participating runners and coaching staff.

Name:

Please check yes or not if you have experienced any of the following symptoms in the last 14 days:

	YES	NO
COUGH		
SHORTNESS OF BREATH		
FEVER		
CHILLS		
MUSCLE PAIN		
SORE THROAT		
NEW LOSS OF TASTE OR SMELL		

Is there anyone in your household who is showing the symptoms of COVID-19 listed above or has been diagnosed with COVID-19?

YES	
NO	

Have you been in contact with anyone who is exhibiting the symptoms of COVID-19 above who has not been tested or is awaiting test results?

YES	
NO	

Temperature: _____

Name: _____ Phone: _____

Email: _____

Signature: _____