

**TODAY'S DATE:** \_\_\_\_\_ **TIME:** \_\_\_\_\_

## CFISD ATHLETIC FACILITIES GAME DAY WORKERS COVID-19 SCREENING

PLEASE READ EACH QUESTION CAREFULLY	PLEASE CIRCLE THE ANSWER THAT APPLIES TO YOU	
Have you experienced any of the following symptoms in the past 48 hours: <ul style="list-style-type: none"> <li>• fever or chills</li> <li>• cough</li> <li>• shortness of breath or difficulty breathing</li> <li>• fatigue</li> <li>• muscle or body aches</li> <li>• headache</li> <li>• new loss of taste or smell</li> <li>• sore throat</li> <li>• congestion or runny nose</li> <li>• nausea or vomiting</li> <li>• diarrhea</li> </ul>	<b>YES</b>	<b>NO</b>
Within the past 14 days, have you been in close physical contact (6 feet or closer for at least 15 minutes) with a person who is known to have laboratory-confirmed COVID-19 or with anyone who has any symptoms consistent with COVID-19?	<b>YES</b>	<b>NO</b>
Are you isolating or quarantining because you may have been exposed to a person with COVID-19 or are worried that you may be sick with COVID-19?	<b>YES</b>	<b>NO</b>
Are you currently waiting on the results of a COVID-19 test?	<b>YES</b>	<b>NO</b>

<b>Did you answer NO to ALL QUESTIONS?</b>	Access to facilities is <b>APPROVED</b> . Please turn this into game day administrator. Thank you for helping us protect you and others during this time.
<b>Did you answer YES to ANY QUESTION?</b>	Access to facilities <b>NOT APPROVED</b> . You will not be able to enter our facilities. Thank you for helping us protect you and others during this time.

**Printed Name:** \_\_\_\_\_

**Signature:** \_\_\_\_\_

