

Symptom Checking/Attendance Record

Sport: _____

Level/Group: _____

Week of: _____

Check mark indicates that the participant was present and temp/symptom checked for that day

	Athlete/Coach	M ____	Tu ____	W ____	Th ____	F ____	Sa ____
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Have you or anyone in regular close contact to you tested positive for COVID 19 in the last 2 weeks?

***If so, have you been cleared by health department guidelines?**

Are you or anyone you are in regular close contact with experiencing any of the following symptoms:

*** Cough, Shortness of Breath, or Difficulty Breathing? * Fever or Chills?**

*** Muscle or Body Aches? * Vomiting or Diarrhea? * New Loss of Taste or Smell?**