COVID-19 Daily Pre-screening Questions

Player Name: _____ Date: _____

Parent/Guardian Cell: _____ Sport: Stafford Roller Hockey

Are you experiencing any of the following symptoms?	**Please Circle One**	
1. Fever (≥ 100.4°F)	**YES**	**NO**
2. Cough or shortness of breath	**YES**	**NO**
3. Sore Throat	**YES**	**NO**
4. Chills	**YES**	**NO**
5. Muscle aches or rigors	**YES**	**NO**
6. Headache	**YES**	**NO**
7. New loss of taste or smell	**YES**	**NO**
8. Abdominal pain, nausea, vomiting or diarrhea	**YES**	**NO**
Have you had close contact with someone who is currently sick?	**YES**	**NO**
Have you been diagnosed with COVID-19 in the past three weeks or have reason to believe you have COVID-19?	**YES**	**NO**
Have you traveled or had close contact with anyone who has traveled internationally in the last 14 days?	**YES**	**NO**

_____ **Temperature reading today**