Elizabethtown Lacrosse Club Pre-practice/play Screening Form

\*TEMPETURE MUST BE TAKEN WITHIN 1HR MAX BEFORE PRACTICE/GAME

Player/Coach Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Team: \_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_

Temperature: \_\_\_\_\_\_\_\_\_\_\_\_

1a. In the last 7 days have you had any of these new symptoms:

* Cough
* Shortness of breath
* Difficulty breathing
* Fever

No\_\_\_\_\_\_\_ Yes \_\_\_\_\_\_\_

If “NO”, move to question #1b.

If “YES” to at least one symptom follow guidelines of your school district’s policy, CDC, and contact ELC at [rheemsaa@lacrosse.com](mailto:rheemsaa@lacrosse.com)

1b. In the last 7 days have you had at least two of these new symptoms:

* Shaking with chills
* Muscle pain
* Headaches
* Sore throat
* Loss of taste or smell
* Diarrhea\* (\*Diarrhea: >3 loose or liquid stools/day)

No \_\_\_\_\_\_\_ Yes \_\_\_\_\_\_

If “NO”, move to question #2.

If “YES” to at least 2 symptoms follow guidelines of your school district’s policy, CDC, and contact ELC at [rheemsaa@lacrosse.com](mailto:rheemsaa@lacrosse.com)

2. In the last 14 days, have you been in personal contact with someone with suspected or

confirmed COVID-19 or do you have a pending COVID-19 test?

No \_\_\_\_\_\_ Yes \_\_\_\_\_\_

If answers are all “NO”, player may proceed.

If “YES”, follow guidelines of your school district’s policy, CDC, and contact ELC at [rheemsaa@lacrosse.com](mailto:rheemsaa@lacrosse.com)

I certify that the information above is true and correct to the best of my knowledge.

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Parent/Guardian Signature Parent/Guardian Print

