COVID-19 Daily Pre-screening Questions

Name of Player : ____ Date: ____________________

Parent/Guardian Cell: ____ Sport: ___Soccer_____________

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, not related to workouts/exercise	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 or in a state NJ requires quarantine for in the last 14 days? YES NO

If you took your temperature this morning, what was the reading? _________________________

To participate in CESC Training or Games, each player must complete this form daily before every workout.

Temp reading completed by reviewer: ________________________________

____________________________________ ___________ ____________

Signature of reviewer **Date** **Time**