COVID-19 SOCCER SCREENING
GREAT BASIN YOUTH SOCCER LEAGUE

Name: _______________ Team#______ Coach__ Team Official__ Referee___ Parent___

If an athlete, coach or spectator answers "YES" to any of the following questions, they should be advised to go home, stay away from other people and contact their primary care provider or local health authority for further instructions.

Please answer "YES" or "NO" to each question:

1. Have you experienced any of the following symptoms in the past 48 hours?

	YES	NO
Fever or Chills		
Cough		
Shortness of breath or difficulty breathing		
Muscle or body aches		
Headache		
New loss of taste or smell		
Sore throat		
Congestion or running nose		
Nausea or vomiting		
Diarrhea		

2. 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 a confirmed case of COVID-19 or with anyone who has any symptoms consistent with COVID-19? Yes __ No __

3. 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? Yes __ No __

4. Are you currently waiting on the results of a COVID-19 test? Yes __ No __