Southampton Township Recreation Association

COVID 19 Daily Pre-screening Questions

Name of Athlete: _____ Date: _____

Parent/Guardian completing this form:_____

Is the athlete experiencing any of the following symptoms?	**Please Circle One**	
1. Fever (≥ 100.4℉)	Yes	No
2. Cough of 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 head contact with someone who is currently sick?	Yes	No
Have you been diagnosed with COVID-19 in the past three weeks or have you reason to believe you have COVID-19?	Yes	No
Have you traveled internationally or to any of the states on the quarantine list In the past 14 days?	Yes	No
Temperature at check-in:	_____	

To participate in practice/games, each athlete must complete this form daily before every workout.

Adapted from the NJ State Interscholastic Athletic Association