Screening Questionnaire
Please Fill Out Completely

Updated: 5/18/2020

Date:_____ **Time**: _____

First Name:_____**MI**:_____**Last Name:** _____

DOB____/___/_____**Athlete Phone Number:** _____

SECTION 1					
Do you have any fever?			No ☐	Yes ☐	
Have you been having chills?	No ☐	Yes ☐	Chills with Shaking? No ☐	Yes ☐	
Do you have any body aches?			No ☐	Yes ☐	
Do you have any muscle pains?			No ☐	Yes ☐	
IF Yes to any above then: Take Temperature			Actual Temp:_____		
SECTION 2 **Do you have any of the following symptoms:**					
Recent/New Onset Coughing (not related to allergy or COPD)			No ☐	Yes ☐	
Recent/New Onset Headache			No ☐	Yes ☐	
Nasal Congestion (not related to allergies or sinus infections)			No ☐	Yes ☐	
Recent/New Onset Sore Throat			No ☐	Yes ☐	
Recent/New Onset Shortness of Breath (not related to chronic disease)			No ☐	Yes ☐	
Recent/New Onset Diarrhea			No ☐	Yes ☐	
Recent/New Onset Nausea/Vomiting			No ☐	Yes ☐	
Recent/New Onset Fatigue/Malaise			No ☐	Yes ☐	
Do you have an Upper Respiratory Illness?			No ☐	Yes ☐	
SECTION 3 **COVID-19 Exposure**					
Are you living with someone that is quarantined or furloughed?			No ☐	Yes ☐	
Have you been in contact with an individual positive for COVID-19?			No ☐	Yes ☐	
Have you been in contact with a Person Under Investigation (PUI) COVID-19?			No ☐	Yes ☐	