Blackheath Field Hockey Club

Covid-19 Daily Pre-screening Questions

Name of Athlete: _____ Date: _____

Parent/Guardian Cell: _____ Sport: _____

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	**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 in the last 14 days?	**YES**	**NO**

Athlete's temperature reading at beginning of practice/ game: _____

Athlete's temperature recorded by: _____

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