CASL/MAYS Covid 19 Pre-Screen Form

Team: Todays Date:

Staff: COACH:

	Player name:		Q#1 (Y/N)	Q#2 (Y/N)	Q#3 (Y/N)	Q#4 (Y/N)	Temp (Y/N)
1							
2							
3							
4							
5							
6							
7							
8							
9							
1							
11							
12							
13							
14							
15							
16							
17							
18							
19							
20							
21							
22							
23							
24							

Question 1: In the last 24 hours, without the aid of medicaton, have you had a temperature of 100.4F or greater?

Question 2: In the last 2 weeks, have you experienced any flu-like symptoms including the following:
persistent cough, respiratory distress, chills, body aches, sore throat and/or headache?

Question 3: In the last 2 weeks, have you had loss of taste and/or smell?

Question 4: In the past 2 weeks have you been diagnosed with COVID-19?

Temperature: Was your temp below 100.4 before arriving to the game?