Inline Skating Club of America- Daily Health Form- Hockey Department

Participants Name_____

Participants Phone #_____

Date:_____

Have you experienced any of the following symptoms in the past 48 hours:

• fever or chills	___YES	___NO
• cough	___YES	___NO
• shortness of breath or difficulty breathing	___YES	___NO
• fatigue • muscle or body aches	___YES	___NO
• headache	___YES	___NO
• new loss of taste or smell	___YES	___NO
• sore throat	___YES	___NO
• congestion or runny nose	___YES	___NO
• nausea or vomiting	___YES	___NO
• diarrhea	___YES	___NO

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 laboratory-confirmed COVID-19 or with anyone who has any symptoms consistent with COVID-19? ___YES ___NO

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

Are you currently waiting on the results of a COVID-19 test? ___YES ___NO

By signing below, I agree that all above questions have been answered truthfully .

_____

Participants Signature Date