Last Name: _____ First Name: _____
Date: _____

Destination (Please Circle): Volleyball

Clinic Camp Tournament Private Academy

Other:_____

Respiratory Infectious Disease Screening

1. Have you recently tested positive or presumptive positive for COVID-19?

   YES NO

2. Do you currently have a fever (100. 4˚ F) or higher or feel like you may have a fever?

   YES NO

3. Do you currently have any symptoms of respiratory illness such as cough or shortness of breath?

   YES NO

4. Have you recently traveled from an area with widespread or ongoing community spread of COVID-19?

   YES NO

5. Have you had contact with a patient, family member, or friend that is under investigation for Coronavirus (COVID-19)?

   YES NO