Flyers Voorhees Youth Hockey Club, Inc.

COVID-19 Health Screening Questionnaire

To participate in or attend any game, practice, training, competition, tournament, clinic, program, tryout or other event or activity (each, an “Event”) sponsored, sanctioned or organized by, or associated with Flyers Voorhees Youth Hockey Club, Inc. (the “Organization”), this COVID-19 Health Screening Questionnaire (this “Questionnaire”) must be completed and signed by the participant or attendee or, if the participant is a minor, by the minor participant’s parent, guardian or other legal representative.

***Please complete this Questionnaire before arriving at the Event and provide a signed copy to a designated representative of the Organization at the Event. A separate Questionnaire must be provided for each participant and attendee. Each participant and attendee must undergo a temperature check by a representative of the Organization at the Event.***

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| --- | --- | --- |
| Name:   (Please type or print full name or participant or attendee) |  | Date: |
| Temperature: °F  (To be completed by a representative of the Organization at the Event) |  | Phone: |

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| **IF THE ANSWER TO ANY OF THE QUESTIONS BELOW IS “YES,” DO NOT COME TO THE EVENT. YOU WILL NOT BE PERMITTED TO PARTICIPATE OR ATTEND.** |

|  |  |  |
| --- | --- | --- |
|  | **Please circle one** | |
| Is the participant or attendee experiencing any of the following: |  | |
| Fever (≥ 100.4°F)\* | **Yes** | **No** |
| Sore throat | **Yes** | **No** |
| Cough or shortness of breath (for participants with chronic allergic/ asthmatic cough, a change in their cough or shortness of breath from baseline) | **Yes** | **No** |
| Diarrhea, vomiting, or abdominal pain | **Yes** | **No** |
| New onset of headache, especially with a fever | **Yes** | **No** |
| New loss of taste or smell | **Yes** | **No** |
| Muscle aches | **Yes** | **No** |
| Chills | **Yes** | **No** |
| Has the participant or attendee been diagnosed with COVID-19 in the past three weeks or do you have reason to believe the participant or attendee has COVID-19? | **Yes** | **No** |
| Has the participant or attendee had close contact (within 6 feet for at least 15 minutes) with anyone who has been diagnosed with COVID-19 or who you have reason to believe has COVID-19? | **Yes** | **No** |
| In the last 14 days, has the participant or attendee traveled or had close contact (within 6 feet for at least 15 minutes) with anyone who has traveled internationally or to any of the high risk states identified by the New Jersey Department of Health? | **Yes** | **No** |

By signing below, you confirm that the information provided in this Questionnaire is truthful, accurate and complete to the best of your knowledge.

|  |  |  |
| --- | --- | --- |
| Signature: |  |  |
|  |  |  |
| Name of person signing this Questionnaire: |  |  |
|  |  | (Please type or print) |
| Relationship to minor Participant (if applicable): |  |  |