FLEMINGTON ICE ARENA

FLEMINGTON ICE ARENA COVID-19 DAILY PRE-SCREENING QUESTIONS

Name (Player/Coach/Official): _____ **Date:** _____

Parent/Guardian Name: _____ **Time of Event:** _____

Parent/Guardian Cell: _____ **Team Name:** _____

Player/Parent/Guardian Signature: _____

Are you experiencing any of the following symptoms?	**Please Circle One**	
1. Fever (above 100.3 degrees 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. 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 14 days 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
Have you visited one of the states currently on the NJ quarantine list?	YES	NO
If so, which state and when did you return?	_____	
If you took your temperature this morning, what was the reading?	_____	