STLWest COVID-19 Team Screening

First and Last Name	Team	Completed Screening Questions	Temperature Checked
	Coach		
	Coach		
	Player		
	Player		
	Player		
	Player		
	Player		
	Player		
	Player		
	Player		
	Player		
	Player		
	Player		
	Player		
	Player		
	Player		

COVID-19 SCREENING QUESTIONS

1) Have you experienced any of the following Symptoms in the past 24 hours?

Fever (greater than 100.4^{o})
Shortness of breath or trouble breathing
Loss of smell or taste
New or Worsening Cough
Sore throat different then seasonal allergies
Diarrhea or vomiting.

2) Have you had close contact with anyone diagnosed with COVID-19 in the past 2 weeks?

*** Any person answering yes to any of the above questions will need to leave the facility immediately and can not participate in any STLWest activity until cleared by a health professional.**

Screener Sign _____ **Team _____**

Print Name _____ **Age Group_____**

By signing as the screener I am certifying that the above participants have been screened by me prior to participating in their scheduled activity in the STLWest Athletic Association.

*** THIS FORM MUST BE COMPLETED PRIOR TO AND TURNED IN AT GROUND RULES. GAMES WILL NOT BEGIN UNTIL BOTH TEAMS HAVE SUBMITTED THE COVID-19 SCREENING FORM TO THE UMPIRE. ANY LATE ARRVING PARTICIPANTS MUST BE SCREENED PRIOR TO JOINING THE ACTIVITY.**

Location (Circle one)

Date _____ **BAA EAA ESA PAA** **Field # _____ Time _____**