East Coast Power Volleyball
COVID-19 Self-Assessment Form

*This form is to be filled out within **2 hours** of your scheduled start time and to be signed and handed in at check in. You will not be allowed to participate without this completed form or if you are exhibiting any of the below symptoms.

Symptoms Include:

Cough
Difficulty breathing
Fever (100.5 F or above)
Chills
Sore throat
Loss of taste or smell

Name: _____

Date: _____

Programming Start Time: _____

Current Temperature: _____

Time Taken: _____

Have you had a cough, shortness of breath/difficulty breathing, a fever, chills, muscle pain, sore throat or loss of taste or smell within the last 14 days?

Yes or No

Have you been in contact with anyone that has had a cough, shortness of breath/difficulty breathing, a fever, chills, muscle pain, sore throat, or loss of taste or smell within the last 14 days?

Yes or No

Signature of Attendee or Parent/Guardian: _____