RLL Indoor Cage COVID-19 Form

****This form must be filled out by each parent/guardian prior to each clinic****

Date: _____ Completed By: _____ Relationship: _____

Player First Name: _____ Player Last Name: _____

Clinic Day: _____ Clinic Time: _____

1. In the last 14 days have you, your child or anyone in your direct family traveled outside the US or to an area in the US where COVID-19 is spreading?

   YES ☐ NO ☐

2. In the last 14 days, did you, your child or anyone in your direct family care for or have close contact with someone diagnosed with COVID-19? Or Is in Quarantine or is presumptive positive for COVID-19?

   YES ☐ NO ☐

3. In the last 14 days, has your child, your or anyone in your direct family had any of the following symptoms: Fever (over 100.4) or Chills, Cough, Shortness of breath or difficulty breathing, Fatigue, Muscle or body aches, Headache, New loss of taste or smell, Sore Throat, Congestion or runny nose, Nausea or Vomiting, Diarrhea

   YES ☐ NO ☐

If an individual answers **YES** to any of the screening questions, immediately contact your doctor and stay home until advised otherwise by your doctor. The RLL Safety Officer should also be notified as soon as possible.

Parent/Guardian Name: _____ (print)

Parent/Guardian Name: _____ (signature)

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CLINIC DIRECTOR TO COMPLETE:

Is the Result of today's on-site Touchless Thermometer Screening above 100.4 degrees F?

YES ☐ NO ☐