COVID-19 Screening Form

Date: ____________________ Name:___________________________________

Reason for entering facility: <u>**RI Warriors Fall Season Practice**</u>

Please let us know if you have had any of the following:

	Yes	No
Fever (temperature of 100F or more)		
Cough		
Shortness of breath or difficulty breathing		
Body aches		
Chills		
Runny nose or stuffy nose		
Sore throat		
Diarrhea		

If the answer to any question is “yes”, the person should be excluded from the facility until:

- They are completely free of symptoms for 72 hours, AND
- 7 days have passed since their first symptoms started

In the last 14 days:

	Yes	No
Has anyone in your household been diagnosed with COVID-19?		
Have you been told to quarantine yourself by any public health authority? If so, when does/did your 14-day quarantine end?		
Have you been in close contact (less than 6 feet for a prolonged period) with someone who has tested positive for COVID-19?		
Have you traveled anywhere outside of the 50 United States or on a cruise?		
Have you traveled anywhere in the United States by commercial airlines?		

If the answer to any question is “yes”, the person should be excluded from the facility and should self-quarantine until 14 days have passed since the time of potential exposure/travel.

Do not write below this line. Official Use Only.

Staff signature: ____________________________

Cleared to enter facility?

☐ yes ☐ no