Colonie Soccer Club
Self-Screening Questionnaire

Last Name: _____ First Name: _____

Date of Birth: _____ Today's Date: _____

Using a thermometer, take your own temperature.

1. Is your temperature equal to or greater than 100.0 degrees Fahrenheit?
   ___ No. Go to the next question.
   ___ Yes. No further screening is needed. You may <u>not</u> participate in the Colonie Soccer Club activity at this time.

2. Did you have any known close contact with a person confirmed or suspected to have COVID-19 in the past 14 days?
   ____ No. Go to the next question.
   ____Yes. No further screening is needed. You may <u>not</u> participate in the Colonie Soccer Club activity at this time.

3. Are you currently experiencing **ANY** of the following symptoms?
   - Cough (new or worsening)
   - Shortness of Breath (new or worsening)
   - Troubled Breathing (new or worsening)
   - Fevers
   - Chills
   - Muscle Pain (new or worsening)
   - Headache (new or worsening)
   - Sore Throat (new or worsening)
   - New loss of taste
   - New loss of smell

   ____ No. Go to the next question.
   ____Yes. No further screening is needed. You may not participate in the Colonie Soccer Club activity at this time.

4. Have you tested positive for COVID-19 through a diagnostic test in the past 14 days?
   ___ No. Go to the next question.
   ___Yes. No further screening is needed. You may <u>not</u> participate in the Colonie Soccer Club activity at this time.

Signature: _____ **Date: _____**
(Parent/Legal Guardian if 18 years old or younger)
Name (print): _____
Phone/E-mail: _____