Colonie Soccer Club
Self-Screening 2020-21 Agreement

Player Last Name: _____ Player First Name: _____

Date of Birth: _____ County of Residence: _____

As the parent/guardian of the player named above, I agree that their temperature will be taken and the self-screen questions will be reviewed prior to my player attending any Colonie Soccer Club (CSC) practice, game or activity for the entire 2020-2021 soccer season.

**If the answer is yes to any of the questions below, my player will refrain from participating in the practice, game and/or CSC activity and I will notify the coach or a club official immediately.*

1. Is your temperature equal to or greater than 100.0 degrees Fahrenheit?

2. Did you have any known close contact with a person confirmed or suspected to have COVID-19 in the past 14 days?

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

4. Have you tested positive for COVID-19 through a diagnostic test in the past 14 days?

5. Have you traveled outside NYS within the last 14 days, specifically to one that is on the NYS Department of Health's travel advisory list?

Signature: _____ **Date:** _____
(Parent/Legal Guardian if 18 years old or younger)

Name (print): _____

Phone/E-mail: _____