BPSA Health Assessment Form

Player Name: _____ Team Name: _____

Do you have any new or worsening symptoms associated with COVID-19?

Yes _____ No _____

Have you been exposed to anyone being tested for suspicion of COVID-19 in the past 14 days?
Yes _____ No _____

Are any members of your household in quarantine for COVID-19?

Yes _____ No _____

In the past 14 days have you traveled to any one of the "hot spot" States listed at the time travel commenced or at the time travel concluded as listed by the PA Department of Health?
Yes _____ No _____

Have you had a documented fever above 100.4 in the last 48hours?

Yes _____ No _____

Have you had any one or more of the following symptoms today or within the past 24 hours, which is new or not explained by a reason other than possibly having COVID-19.

Yes _____ No _____

- Fever, chills, orrepeated shaking/shivering
- Cough
- Sore throat
- Shortness of breath, difficulty breathing
- Feeling unusually weak or fatigued

- Loss of taste or smell
- Muscle pain
- Headache
- Runny or congested nose
- Diarrhea
- Nausea and vomiting

Parent Signature: _____ Date: _____

If you have answered yes to any of the above, do not attend the BPSA activities you were scheduled to attend. Please refer to the BPSA Return to Soccer Guidelines for instructions.

Issued by the Bethel Park Soccer Association Board of Directors on 8/24/2020