Walton Volleyball – COVID-19 Screening Questionnaire Form

(Please circle)

Y / N Have you, or anyone in your family, been exposed to anyone who has tested positive for COVID-19 in the past two weeks?

Y / N Have you or your player developed any of the following symptoms within the past 10 days?

(Please mark all that apply.)

_____ Fever (100.4 or higher)

_____ New Cough not associated with any other illness/allergy

_____ Shortness of Breath

_____ Sore throat

_____ New loss of taste or smell

_____ Body/muscle aches or chills

_____ Headache

_____ Diarrhea or Nausea

_____ Athlete's Printed Name Date _____

_____ Athlete's Signature

_____ Parent's Printed Name Date _____

_____ Parent's Signature