



## COVID-19 Questionnaire

Player Name \_\_\_\_\_ Club Name \_\_\_\_\_ Team Name/Age  
Group \_\_\_\_\_

1) Has the player or anyone that they have been in contact with in the past 48 Hrs, especially family members, had any of the following symptoms? Fever, Chills, Cough/Sore Throat, Shortness of breath, Loss of taste or smell or Head/muscle aches?

Yes

No

2) Has the player or members of their household traveled outside of our local area or outside of the US within the last 14 days?

Yes

No

3) Has the player, or member of the household, recently been in contact with someone who has tested positive for COVID-19 or any communicable disease in the past 14 days?

Yes

No

4) If you answered "Yes" to the last question, please indicate the approximate dates of illness.

MM/DD/YYYY

*I confirm that the above questions have been answered truthfully and to the best of my knowledge. Furthermore, I understand that answering yes to any of the above questions, my children will not be able to attend practice or match.*

\_\_\_\_\_  
Signature of Parent/Guardian

\_\_\_\_\_  
Print Name of Parent

\_\_\_\_\_  
Print name of Player

\_\_\_\_\_

Date