COVID-19 QUESTIONNAIRE

Name: _____

Date of Birth: _____ Age: _____

Player Temperature upon arrival (insert below): Individual taking temperature:

Monday	*Tuesday*	*Wednesday*	*Thursday*	*Friday*

- Have you traveled in the past 14 days to any regions affected by COVID-19? _____
- Have you been in contact with any confirmed COVID-19 positive individuals: _____
- Do you have (circle all that apply): heart disease, lung disease, kidney disease, diabetes, or any auto immune disorders?

Are you experiencing any of the symptoms below (yes/no)

	Monday	Tuesday	Wednesday	Thursday	Friday
Acute respiratory illness					
100.4+ degree temp					
Coughing					
Shortness of Breath					
Diarrhea					
Vomiting					
Fatigue					
Headache					
Body Ache					
Loss of taste/smell					

To parent: Have you signed, agreed to, and submitted the Capital Soccer Incorporated communicable disease release of liability agreement? If "yes", please sign and date below to confirm.