COVID-19 Daily Questionnaire

If you or a family member have any of these pre-existing conditions please contact your athletic trainer directly.

*High Blood Pressure *Chronic Lung Disease *Heart Conditions * Diabetes
*Asthma * Severe Obesity *Cancer Patients * Chronic Kidney or Liver Disease
*Anyone over 65 years and older

Please complete this form every day before you arrive at {HIGH SCHOOL's} practice.

Don't forget to have your face covering on and to bring your own FILLED water bottle each day.

Full Name_____

In the past 24 hours have you had any of these symptoms? *

	YES	NO
Fever		
Cough		
Sore Throat		
Shortness of Breath		
Chest Pain, Pressure or Tightness		
Loss of Test or Smell		

Have you been in close contact with or cared for someone with COVID-19? *

YES NO

Daily Temperature: _____ Today's Date:_____