Futsal516 COVID-19 Screening Form

Player Name	
Player's Team Name	
Player's Parent Mobile Number	
Date of Event	

Circle "Yes" or "No" To All Questions Below

- If you answer "Yes" to any of the questions below you are not eligible to participate in today's event. ***Bring this form with you to Futsal516 and hand it in to the front desk.***

Question		
Are you experiencing shortness of breath or trouble breathing?	**YES**	**NO**
When you took your temperature today, did you have a temperature of 100.4° F or higher?	**YES**	**NO**
Are you experiencing a sore throat?	**YES**	**NO**
Are you coughing?	**YES**	**NO**
Are you experiencing repeated shaking with chills?	**YES**	**NO**
Do you have muscle aches?	**YES**	**NO**
Are you experiencing gastrointestinal changes? Or diarrhea?	**YES**	**NO**
Have you noticed a loss of smell or taste?	**YES**	**NO**
In the last 14 days, have you had contact with a known or suspected COVID-19-positive person?	**YES**	**NO**
In the last 14 days, have you traveled outside of New York State to an area that has a high incidence of COVID-19?	**YES**	**NO**
What was your temperature when you took it today?		

Please Confirm Below

Please confirm you are aware only 1 Parent and no siblings are permitted to attend the event today.	**Initial Here_____________________**