



Daily Health Screening Questionnaire for CVGSL Coaches, Players & Parents

*Prior to coming in person to any CVGSL meetings, practices, or games, please read and answer the questions below truthfully. **If you answer yes to any question, please stay home, do not attend the event.***

1. In the past 10 days, was the participant instructed to isolate as a result of flu-like symptoms?

YES

NO

2. In the past 10 days, was the participant diagnosed with COVID-19 or did the participant have a test confirming they had the virus?

YES

NO

3. Within the past 14 days, has the participant had close contact with anyone who was diagnosed with COVID-19 or who had a test confirming they have the virus?

YES

NO

4. Since the participant last participated in CVGSL activities, has the participant had any of these symptoms?

Symptoms: **Fever (greater than 100°F)**, chills, cough, shortness of breath or difficulty breathing, fatigue, muscle or body aches, headache, new loss of taste or smell, sore throat, congestion or runny nose, nausea or vomiting, diarrhea, seems sick or like they are starting to get sick .

YES

NO

Print Name: _____

Date: _____

Sign Name: _____

I am a (circle): Coach Player Parent