



# LIBERTY YOUTH BASEBALL COVID-19 SYMPTOM CHECKLIST

Participant Name:

Does the participant (team official/player/member) have any of the below symptoms?

	YES	NO
Fever (greater than 100.4 F)?	<input type="radio"/>	<input type="radio"/>
Cough?	<input type="radio"/>	<input type="radio"/>
Shortness of breath/difficulty breathing?	<input type="radio"/>	<input type="radio"/>
Sore throat?	<input type="radio"/>	<input type="radio"/>
Runny nose?	<input type="radio"/>	<input type="radio"/>
Has anyone in your household experienced any of the above symptoms in the last 14 days?	<input type="radio"/>	<input type="radio"/>
Have you, or anyone in your household been in contact in the last 14 days with someone who is being investigated as a suspected case of COVID-19?	<input type="radio"/>	<input type="radio"/>
Are you currently being investigated as a suspected case of COVID-19?	<input type="radio"/>	<input type="radio"/>
Have you tested positive for COVID-19 within the last 10 days?	<input type="radio"/>	<input type="radio"/>

Signature:

Date: