SECAUCUS RECREATION DEPARTMENT
COVID-19 DAILY PRE-SCREENING QUESTIONS

Name of Player: _____ Date: _____

Parent/Guardian Name: _____ Sport: _____

Parent/Guardian Cell: _____

Are you experiencing any of the following symptoms?	**Please Circle One**	
1. Fever (≥ 100.4°F)	YES	NO
2. Cough or shortness of breath	YES	NO
3. Sore Throat	YES	NO
4. Chills	YES	NO
5. Muscle aches or rigors	YES	NO
6. Headache	YES	NO
7. New loss or taste or smell	YES	NO
8. Abdominal pain, nausea, vomiting or diarrhea	YES	NO

Have you had close contact with someone who is currently sick?	YES	NO
Have you been diagnosed with COVID-19 in the past three weeks or have reason to believe you have COVID-19?	YES	NO
Have you traveled or had close contact with anyone who has traveled internationally in the last 14 days?	YES	NO
Have you visited one of the states currently on New Jersey quarantine list?	YES	NO

If so, which state did you travel to and when did you return from travel? _____

If you took your temperature this morning, what was the reading? _____