COVID-19 SCREENING TOOL

Athlete's Name:_____School/Parish:_____

SYMPTOMS

Has your student had any of the following symptoms in the past three days that are not explained by allergies or non-infectious cause?	Yes	No
Cough		
Shortness of Breath or Difficulty Breathing		
Fever or Chills		
Muscle or Body Aches		
Sore Throat		
Headache		
Nausea or Vomiting		
Diarrhea		
Runny Nose or Stuffy Nose		
Fatigue		
Recent Loss of Taste or Smell		

RISK FACTORS

	Yes	No
Has your student been in close contact (less than six feet) with anyone with COVID-19?		
Has your student traveled anywhere outside the 50 United States in the past 14 days or to a state with a high positivity rate?		
Has your student been directed to quarantine or isolate by the Rhode Island Department of Health or a healthcare provider in the past 10 days?		

IF YOU HAVE ANSWERED "YES" TO ANY OF THE QUESTIONS ABOVE, AND YOU **CANNOT** EXPLAIN THESE SYMPTOMS BY KNOWN ALLERGIES OR NON-INFECTIOUS ILLNESSES, THEN YOUR CHILD CANNOT PARTICIPATE IN A PRACTICE OR CAL GAME TODAY.

Parent/Guardian signature or initials_____

Date_____