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
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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

Has your student been in close contact (less than six feet) with anyone with COVID-19? | Yes | No
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Has your student traveled anywhere outside the 50 United States in the past 14 days or to a state with a high positivity rate? | Yes | No
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? | Yes | No

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

Parent/Guardian signature or initials________________________________________

Date______________________________