

Player Name _____ TEAM _____ DATE _____

Is the player or anyone in your home awaiting the results of a Co-Vid test? YES NO

Has the player or anyone in the household had any of the following: Fever, shortness of breath, loss of taste or smell, headaches, fatigue, weakness and/or runny nose, sore throat, sneezing, watery eyes that is not allergy related? YES NO

In the last 14 days has the player or any family member traveled to one of the states which recommend quarantining upon returning? YES NO If so, where? _____

Parent Signature _____ Date _____

Phone Number of transportation _____

Reviewed by: _____ Date _____

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