Coronavirus COVID-19 Screening Questionnaire

Name_____ Student ID#_____ Date _____

Phone number _____ Coach(s) Name _____

Sport(s) _____

1. In the last 14 days have you traveled outside your normal, daily routine? YES NO
2. Do you have new or worsening onset of any of the following symptoms: fever, cough, shortness of breath, difficulty breathing, runny nose, sore throat, chills, body aches, fatigue, headache, loss of taste/smell, eye drainage, diarrhea, congestion?
   YES NO
3. If "Yes " to the above question, please list symptoms below:

4. Have you been exposed to someone being tested for COVID-19 or who has symptoms compatible with COVID-19?
   YES NO

5. Are any members of your household a close contact on quarantine for exposure to COVID-19?
   YES NO

If you have answered "yes" to any of these questions: Please remain home or leave premises of Judson ISD and contact your coach • If outside these hours, contact your coach, remain at or return home. Contact Judson ISD for further screening and direction. I understand that I have the responsibility to immediately notify a coach should my responses on this questionnaire change.

Participants Name: _____

Participants Signature: _____

Date: _____

***If unable to electronically submit, please print, complete and submit to coach. Copies will be made available in person. ***