Passaic County Vocational Schools Athletic Department

COVID-19 Daily Pre-screening Questions

Name of Student: _____ Date: _____

Parent/Guardian Cell: _____ Sport:

_____ **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 of 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**

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

To participate in workouts during the summer recess period, each student must complete this form daily before every workout. Screening questionnaires must be completed prior to arriving on school grounds.