Covid Health Questionnaire updated 10/20/20

1. Have you/participant had COVID-19 within the last 14 days?
   Yes No
2. In the last 14 days, have you/participant been in close contact with anyone you know: (a) who exhibited the symptoms of COVID-19, (b) who is/was being tested for COVID-19, (c) who has COVID-19, or (d) who was exposed to someone with COVID-19?
   Yes No
3. Have you/participant had any signs or symptoms of a fever in the past 24 hours such as chills, sweats, felt "feverish", or had a temperature that is elevated for you or 100.4F or greater?
   Yes No Today's Temp________
4. In the past 24 hours, have you/participant experienced the following unrelated to seasonal allergies:

Fever	Yes	No	Cough	Yes	No
Loss of taste of smell	Yes	No	Sneezing	Yes	No
Aches and Pains	Yes	No	Sore Throat	Yes	No
Runny / Stuffy Nose	Yes	No	Diarrhea	Yes	No
Shortness of Breath	Yes	No	Headaches	Yes	No
Nausea or Vomiting	Yes	No	Fatigue	Yes	No

5. In the last two weeks have you/participant traveled internationally or to any of the following states:

   Alabama, Alaska, Arizona, Arkansas, Colorado, Delaware, Florida, Georgia, Guam, Idaho, Illinois, Indiana, Iowa, Kansas, Kentucky, Louisiana, Maryland, Michigan, Minnesota, Mississippi, Missouri, Montana, Nebraska, Nevada, New Mexico, North Carolina, North Dakota, Ohio, Oklahoma, Puerto Rico, Rhode Island, South Carolina, South Dakota, Tennessee, Texas, Utah, Virginia, West Virginia, Wisconsin and Wyoming.
   Yes No

Participants Name (please print):_____________________________

Signature of Responsible Adult:______________________________ Date:_________

Regardless of how you answer the questions provided in this survey, if you have symptoms consistent with COVID-19 or feel you may be developing symptoms consistent with COVID-19, you cannot attend or participate in any youth soccer activities and should contact a local healthcare professional.