COVID-19 SCREENING FORM

1) Does your child have a temperature over 99.8? □ NO
2) Does your child have any NEW or INCREASED symptoms that include cough, runny nose, sore throat, loss of taste or smell, muscle or body aches, headache, diarrhea, vomiting, nausea? □ NO
3) Has your child been in close contact (within 6 feet for more than 15 min) with someone who has tested positive for Covid-19 or has symptoms of Covid-19 in the last 14 days? □ NO
4) Does your child have a pending Covid-19 test because he/she is symptomatic or has been identified as a close contact? □ NO
5) Has your child travelled internationally in the last 7 days? □ NO

****If answer is "yes" to any question, then not allowed to practice.**

SWIMMER NAME (PRINT): _____ DATE:_____

PARENT SIGNATURE: _____