Daily COVID-19 Medical Form

Player's Name: _____

Player's Team: _____

Today's Date: _____

Player's Self-Reported Temperature: _____

Symptoms: Check all that apply

□ Fever / Chills

□ Cough, Shortness of Breath, or Difficulty Breathing

□ Sore Throat

□ Loss of Taste or Smell

□ Headache

□ None of The Above

Have you had any contact with someone that has tested positive for COVID-19

□ Yes

□ No

Name of participant: _____

Participant signature: _____ Date: _____