

WVSA Symptom Screening Form

Questions below are to be answered for individual who's name is listed to the left

If answer is "YES" to Questions 1-5 or "No" to Questions 6&7 below, please have individual leave the field.

Date of	of	Training:			

Coach/ Team & Club Admin/ Youth or Adult Player's Name	Time	Q1: Do you have a cough, shortness of breath or sore throat?	Q2: Have you been in close contact with a confirmed case of COVID-19?	Q3: Have you had vomitting or diarrhea in the last 24 hrs?	Q4: Have you	Q5: Have you had a new loss of taste or smell?	Q6: Is your temperature normal today?	Q7: Has all of the player's equipment and clothing been cleaned since the last time it was used?	If a minor, parent/ guardian's name who answered questions.
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