Covid-19 Screening Questionnaire (V1.0)

All visitors must answer the screening questions listed below. After completion, you will be notified if you have passed or failed the screening. If failed, you must exit the facility and contact your primary care provider and notify them.

Read The Questions Below Then Check Off The Appropriate Answer Box (Yes / No)

(1) Please let us know if you have any of the following symptoms or signs listed below that have appeared within the past 5 days…	**Yes ↓**	**No ↓**
Shortness of breath?		
Sore throat?		
Runny nose, sneezing or nasal congestion? (excluding seasonal allergies)		
Hoarse and / or crackling voice?		
Difficulty swallowing?		
New smell or taste disorder(s)?		
Nausea/vomiting, diarrhea, abdominal pain?		
Unexplained fatigue/malaise?		
Chills or Headaches?		

(2) Have you traveled outside of **VIRGINIA and/or THE UNITED STATES** or had close contact with anyone that has traveled outside of **VIRGINIA and/or THE UNITED STATES?**		
(3) Do you have a fever (or recently developed one) ?		
(4) When out in public, do you leave your face unprotected? (i.e if you always wear a mask, answer "no")		
(5) Have you been personally tested for COVID-19 in the past 7 days?		
(5b) If you answered "yes" above, did you test positive? (If you answered "no", proceed to question 6)		
If you answered "yes" to question 5b, your screening is complete		
(6) Have you had close contact with anyone with respiratory illness or a confirmed or probable case of COVID-19?		
If you answered "no" above, your screening is complete		
(6b) If you answered "yes" above, were you wearing PPE the entire time you were in close contact with this person?		

Athlete Name: _____

Parent/Guardian Name: _____

Athlete (18+) or Parent/Gaurdian Signature: _____ **Date:** _____