COVID-19 PARTICIPANT SCREENING FORM

Activity:_____**Date:**_____ _____

Signature of activity supervisor

ANY PARTICIPANT ANSWERING YES TO ANY QUESTION OR RECORDING A TEMPERATURE OF 100 OR ABOVE MUST BE SENT HOME.

NAME	FEVER		SORE THROAT		COUGH		LOSS OF SMELL OR TASTE		SHORTNESS OF BREATH		CLOSE CONTACT TO POSITIVE COVID PATIENT		TEMP	TIME
	YES	NO	YES	NO	YES	NO	YES	NO	YES	NO	YES	NO		
	YES	NO	YES	NO	YES	NO	YES	NO	YES	NO	YES	NO		
	YES	NO	YES	NO	YES	NO	YES	NO	YES	NO	YES	NO		
	YES	NO	YES	NO	YES	NO	YES	NO	YES	NO	YES	NO		
	YES	NO	YES	NO	YES	NO	YES	NO	YES	NO	YES	NO		
	YES	NO	YES	NO	YES	NO	YES	NO	YES	NO	YES	NO		
	YES	NO	YES	NO	YES	NO	YES	NO	YES	NO	YES	NO		
	YES	NO	YES	NO	YES	NO	YES	NO	YES	NO	YES	NO		
	YES	NO	YES	NO	YES	NO	YES	NO	YES	NO	YES	NO		
	YES	NO	YES	NO	YES	NO	YES	NO	YES	NO	YES	NO		
	YES	NO	YES	NO	YES	NO	YES	NO	YES	NO	YES	NO		
	YES	NO	YES	NO	YES	NO	YES	NO	YES	NO	YES	NO		
	YES	NO	YES	NO	YES	NO	YES	NO	YES	NO	YES	NO		
	YES	NO	YES	NO	YES	NO	YES	NO	YES	NO	YES	NO		
	YES	NO	YES	NO	YES	NO	YES	NO	YES	NO	YES	NO		
	YES	NO	YES	NO	YES	NO	YES	NO	YES	NO	YES	NO		
	YES	NO	YES	NO	YES	NO	YES	NO	YES	NO	YES	NO		
	YES	NO	YES	NO	YES	NO	YES	NO	YES	NO	YES	NO		
	YES	NO	YES	NO	YES	NO	YES	NO	YES	NO	YES	NO		
	YES	NO	YES	NO	YES	NO	YES	NO	YES	NO	YES	NO		
	YES	NO	YES	NO	YES	NO	YES	NO	YES	NO	YES	NO		
	YES	NO	YES	NO	YES	NO	YES	NO	YES	NO	YES	NO		
	YES	NO	YES	NO	YES	NO	YES	NO	YES	NO	YES	NO		
	YES	NO	YES	NO	YES	NO	YES	NO	YES	NO	YES	NO		
	YES	NO	YES	NO	YES	NO	YES	NO	YES	NO	YES	NO		
	YES	NO	YES	NO	YES	NO	YES	NO	YES	NO	YES	NO		
	YES	NO	YES	NO	YES	NO	YES	NO	YES	NO	YES	NO		
	YES	NO	YES	NO	YES	NO	YES	NO	YES	NO	YES	NO		