LOBO Lacrosse COVID Health Screening

Date (mm/dd/yy) _____

Volunteer Last Name _____

Volunteer First Name _____

- Have you experienced any of the following symptoms in the past 48 hours? (circle Y or N)
  a. Cough Y / N
  b. Shortness of breath or difficulty breathing Y / N
  c. Chills Y / N
  d. Repeated shaking with chills Y / N
  e. Muscle pain Y / N
  f. Headache Y / N
  g. Sore throat Y / N
  h. Loss of taste of smell Y / N
  i. Diarrhea Y / N
  j. Feeling feverish or measured temperature greater than or equal to 99.6 degrees Fahrenheit Y / N
- Within the past 14 days, have you between in close physical contact (6feet or closer for at least 15 minutes) with a person who is known to have laboratory- confirmed COVID-19 or with anyone wo has any symptoms consistent with COVID-19? Y / N
- Are you currently waiting on results of a COVID-19 test? Y / N
- Current Temperature (taken by adult) _____
- Volunteer Signature _____