COVID-19 Athlete/Coach Monitoring Form

Sport: _____ Date: _____

Student Name	Coach/Screener Name	Pod #	Time	Check the box below for Yes or No										
				Fever		Cough		Sore Throat		Shortness of Breath		Close contact, or cared for someone with COVID-19		Temp (if higher than 100.3°F)
				Yes	No	Yes	No	Yes	No	Yes	No	Yes	No	
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