Staples High School Athletics

COVID-19 Questionnaire

Name: _____ Date: _____

Please circle **YES** or **NO** to the following list of symptoms. Circle **YES** if you have had any of these in the last 14 days, **NO** if you have not:

1.	Fever or chills	YES	NO
2.	Cough	YES	NO
3.	Nasal congestion or runny nose	YES	NO
4.	Sore throat	YES	NO
5.	Shortness of breath or difficulty breathing	YES	NO
6.	Diarrhea	YES	NO
7.	Nausea or vomiting	YES	NO
8.	Fatigue	YES	NO
9.	Headache	YES	NO
10.	Muscle or body aches	YES	NO
11.	New loss of taste or smell	YES	NO

I acknowledge that:

1. I took my temperature before arriving today and it is no higher than 100 degrees
2. That if I have traveled internationally or domestically within the last 14 days, I will notify coach and the athletic trainers, along with follow guidelines put out by the state and quarantine appropriately. More information can be found at: www.ct.gov/Coronavirus under CT Travel Advisory
3. I have not been in contact with someone who had COVID 19 symptoms, or has been diagnosed with COVID 19
4. I have not been instructed to self-quarantine presently
5. All the above health information is accurate

Signature: _____