COVID-19 Coach/Athlete Monitoring Form

			Check and Complete the Column(s) where appropriate			
Name	**Date**	**Time**	**Student answered "NO" to all screening questions**	**Student answered "yes", which question? (ex. A, B)**	**If Yes, What Action Taken (ex. Contact Family and send student home)**	**Follow up (ex. Doctor note, return to play OR student has stayed home for 14 days prior to return)**

A. Do you or have you had a fever above 100.4 F in the last week?
B. Do you or have you had a consistent cough in the last week?
C. Do you or have you had a sore throat in the last week?
D. Do you or have you had congestion and/or a runny nose in the last week
E. Do you or have you had a shortness of breath or fatigue in the last week?
F. Do you or have you had a consistent headache in the last week?
G. Do you or have you had nausea, vomiting, or diarrhea in the last week?
H. Do you or have you had a loss of taste or smell in the last week?
I. Have you been in close contact or cared for anyone diagnosed with COVID 19?