2021-22 COVID-19 Coach/Athlete Symptom Checklist and Verification Form

Name, Phone	County	Fever	Loss of Smell or Taste	Cough	Muscle Aches	Sore Throat	Shortness of Breath	Chills	Headache	Gastrointestinal Symptoms	Close contact, diagnosed or placed in quarantine	Asked to self-isolate or quarantine

I certify that our school has completed the prescreening of each person on our team today before completing our contest/practice. I certify that if I have not understood any information contained in this document, I have sought and received an explanation of the information prior to signing this statement. I certify that we are following our local school and health department policies.

_____ _____

Sport School Name

_____ _____

Coach's Signature Please Print Name and Date

_____ _____

AD/Principal/Superintendent Signature Please Print Name and Date