



## Standardized Screening Assessment

Player's Name: \_\_\_\_\_

Today's Date: \_\_\_\_\_

This Standardized Screening Assessment (SSA); should be completed by the Player's parent/guardian daily and prior to the Player coming to the facilities for training or match, as applicable.

- If all answers NO, Player will come to the facility.
- If any answers YES, Player will not come to the facility, and will contact his primary healthcare provider and notify his Coach

**DAILY TEMPERATURE:**

Time: \_\_\_\_\_

Temperature: \_\_\_\_\_ Method: Choose an item.

Please answer the following questions:

- 1) In the past 14 days, has the Player experienced any COVID-19 symptoms, including but not limited to:

Yes  No  Fever

Temperature: \_\_\_\_\_

Method: Choose an item.

Date last performed: \_\_\_\_\_

Yes  No  Cough

Yes  No  Shortness of breath or difficulty breathing

Description: \_\_\_\_\_

Yes  No  Chills or repeated shaking with chills

Yes  No  Muscle pain

Yes  No  Headache

Yes  No  Sore throat

Yes  No  Chest pain, palpitations or fatigue

Yes  No  New loss of smell or taste

Yes  No  Other

If other please explain: \_\_\_\_\_

- 2) Has the Player traveled internationally or from a location considered high risk for COVID-19 in the past 14 days? Yes  No

- 3) Has the Player been exposed in the last 14 days to anyone that has been diagnosed with COVID-19 or had COVID-19 symptoms? Yes  No

- 4) Is there any other reason to believe that the Player may have been exposed to the virus in the last 14 days? Yes  No

- 5) Has the Player had a documented elevated temperature ( $\geq 38^{\circ}\text{C}$ , or  $\geq 100.4^{\circ}\text{F}$ ) in the last 72 hours? Yes  No

**IF YES TO ANY OF THE ABOVE QUESTIONS, PLEASE CONTACT THE PLAYER'S  
PRIMARY CARE PROVIDER AND PROVIDE NOTICE TO YOUR CLUB COACH**