Shen's Health screening document

Gymnast Name: _____

Date: _____

Contact name: _____ Relationship: _____

Emergency contact number: _____

Today or in the past 24 hours, have you or any household members had any of the following symptoms?

- Fever (temperature of 100.0°F or above), felt feverish, or had chills? YES NO
- Cough? YES NO
- Sore throat? YES NO
- Difficulty breathing? YES NO
- Gastrointestinal symptoms (diarrhea, nausea, vomiting)? YES NO
- Fatigue? YES NO
- Headache? YES NO
- New loss of smell/taste? YES NO
- New muscle aches? (not related to training/practice) YES NO
- Any other signs of illness? YES NO

In the past 14 days, have you had close contact with a person known to be infected with the novel coronavirus (COVID-19)? YES NO

Has athlete had any fever reducing medications today for any reason (Ibuprofen, Tylenol, etc)? YES NO

In signing below, you are acknowledging that you have taken your athletes temperature and found it to be normal. You also state that you have not been near anyone with COVID symptoms in the past 14 days, nor participated in activities not following proper social distancing precautions.

_____ _____

Printed Name of Parent / Legal Guardian Signature of Parent / Legal Guardian

Rev: 6.10.20