

LOLL COVID-19 DAILY HEALTH SCREENING FORM

Each student / youth participant must turn this form into their Coach / Advisor each day.

Date _____
Participant Name _____
Activity _____
Supervisor/Coach _____
Participant Telephone # _____
Emergency Contact _____
Emergency Contact Phone # _____
Drop-Off Time _____ Pick-Up Time _____
Temperature _____

Circle one:

Fever (100.03 or higher) **yes / no**
Any Fever within last 4 - 8 hours **yes / no**
Cough **yes / no**
Shortness of Breath **yes / no**
Chills **yes / no**
Sore Throat **yes / no**
Close contact with anyone with COVID-19 **yes / no**

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