COVID-19 Participant/Coach Monitoring Form

SCHOOL: ____

PERSON RESPONSIBLE: ________________________________

DATE:__________________ TEAM: ____________________

	TEAM	NAME	TEMP	Have you felt any COVID-19 symptoms in the last 5 days?	
1.	Coach			YES	NO
2.				YES	NO
3.				YES	NO
4.				YES	NO
5.				YES	NO
6.				YES	NO
7.				YES	NO
8.				YES	NO
9.				YES	NO
10.				YES	NO
11.				YES	NO
12.				YES	NO
13.				YES	NO
14.				YES	NO
15.				YES	NO
16.				YES	NO
17.				YES	NO
18.				YES	NO
19.				YES	NO
20				YES	NO
21.				YES	NO
22.				YES	NO
23.				YES	NO
24.				YES	NO
25.				YES	NO