Group/Sport_____________ Coach Name______________________ Date ______________________

COVID-19 Athlete/Coach Monitoring Form

Name	Time	Circle Yes/No below										
		Fever in the last 48 hours		Cough/ Sore Throat/ Shortness of Breath		New Loss of Taste or Smell		Vomiting or Diarrhea in the last 24 hours		Close contact with confirmed case of COVID-19		Temp (if higher than 100.3°F)
		Yes	No	Yes	No	Yes	No	Yes	No	Yes	No	
		Yes	No	Yes	No	Yes	No	Yes	No	Yes	No	
		Yes	No	Yes	No	Yes	No	Yes	No	Yes	No	
		Yes	No	Yes	No	Yes	No	Yes	No	Yes	No	
		Yes	No	Yes	No	Yes	No	Yes	No	Yes	No	
		Yes	No	Yes	No	Yes	No	Yes	No	Yes	No	
		Yes	No	Yes	No	Yes	No	Yes	No	Yes	No	
		Yes	No	Yes	No	Yes	No	Yes	No	Yes	No	
		Yes	No	Yes	No	Yes	No	Yes	No	Yes	No	
		Yes	No	Yes	No	Yes	No	Yes	No	Yes	No	
		Yes	No	Yes	No	Yes	No	Yes	No	Yes	No	

Coaches' Signature ______________________________