COVID-19 ATHLETE/COACH MONITORING FORM

DATE: _____

CIRCLE YES/NO

NAME	TIME	FEVER		COUGH		SORE THROAT		SHORTNESS OF BREATH		CLOSE CONTACT, OR CARED FOR SOMEONE WITH COVID-19		TEMP (IF HIGHER THAN 100.3)
		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	
		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	