GRANT COUNTY HIGH SCHOOL

Pre-participation COVID-19 Screening Questionnaire

Name: _____

Email _____

Contact Phone #: _____

Sport/Date: _____

Have you been ill in the last 3 weeks? □ Yes □ No

Have you experienced any of the following symptoms over the last 3 weeks:

Symptom	Yes	No	If yes, please explain:
Fever			
Body Chills			
Extreme Fatigue			
Cough			
Pain/Difficulty Breathing			
Shortness of Breath			
Sore Throat			
Body/Muscle Aches			
Loss of Taste			
Loss of Smell			
Changes in vision/eye discharge			

Have you been or are you currently diagnosed with COVID-19?

□ Yes □ No If yes, please explain: _____

To the best of your knowledge, have you had any direct contact with someone that has a suspected or lab confirmed case of COVID-19?

□ Yes □ No If yes, please explain: _____

Have you self-quarantined due to suspected exposure or symptoms of COVID-19?

□ Yes □ No If yes, please explain: _____

Please list (and date) any places you have traveled outside the state of Kentucky in the last 3 weeks:

_____

Signature:_____Date:_____

Document is to be submitted by all attendees at all events upon gate entry.