Name Date Temperature

Are symptoms related to Covid-19, (including but not limited to: fever, fatigue, dry cough, body ache, shortness of breath, headache, loss of smell or taste, sore throat) present in me or anyone living in my household. Circle one: Yes No

If I, or anyone in my family has traveled out of state in the past 14 days please list location and let your coach know.

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Location

By signing this I acknowledge this information is accurate to the best of my knowledge

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 Parent Signature

Name Date Temperature

Are symptoms related to Covid-19, (including but not limited to: fever, fatigue, dry cough, body ache, shortness of breath, headache, loss of smell or taste, sore throat) present in me or anyone living in my household. Circle one: Yes No

If I, or anyone in my family has traveled out of state in the past 14 days please list location and let your coach know.

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Location

By signing this I acknowledge this information is accurate to the best of my knowledge

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 Parent Signature

Name Date Temperature

Are symptoms related to Covid-19, (including but not limited to: fever, fatigue, dry cough, body ache, shortness of breath, headache, loss of smell or taste, sore throat) present in me or anyone living in my household. Circle one: Yes No

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 Parent Signature

Name Date Temperature

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 Parent Signature