



## COVID-19 Athlete Monitoring Form

Date: \_\_\_\_\_ Swimmers Name: \_\_\_\_\_

Circle Yes/No Below

Fever, Cough, Chills, And/Or Muscle Aches		Sore Throat, Runny Nose, And/Or Loss Of Taste Or Smell		Nausea, Vomiting, And/Or Diarrhea		Shortness Of Breath And/Or Headache		Close Contact, Or Cared For Someone With COVID-19	
Yes	No	Yes	No	Yes	No	Yes	No	Yes	No

**Any person with positive symptoms reported will not be allowed to take part in workouts and should contact his or her primary care provider or other appropriate healthcare professional.**



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