SBSC Daily Self Screening

This form must be filled out by athletes or by the athlete's before reporting to practice
*If the answer is "**Yes"** to any question the athlete will **not** be allowed to practice.*

1.Athlete's Name: Last Name, First Name
_____

2.I am in this practice group. (circle one)
Group 1
Group 2
Group 3

3.Are you experiencing a cough? (circle one)
Yes
No

4. Are you experiencing shortness of breath? (circle one)
Yes
No

5. Are you experiencing any chills? (circle one)
Yes
No

6.Have you experienced a recent loss of taste or smell? (circle one)
Yes
No

7.Are you experiencing any body aches? (circle one)
Yes
No

8.Are you experiencing headaches? (circle one)
Yes
No

9.Are you experiencing a sore throat? (circle one)
Yes
No

10. Have you had close contact with someone with Covid-19, Covid-19 symptoms, or who has tested positive for Covid-19? (circle one)
Yes
No