PAC Health-Screening Questionnaire

Organization/Team Name_____

Participant Name_____ Date_____

Please circle:

Athlete/Trainee Trainer/Coach Supervisor (if also coach, circle both)

Participant, please answer the following questions prior to entering our facility for any of the following new or worsening signs or symptoms of possible COVID-19:

Have you or anyone you have been in close contact with experienced the following within the past 14 days?

- ❑ Cough
- ❑ Shortness of breath or difficulty breathing
- ❑ Chills
- ❑ Repeated shaking with chills
- ❑ Muscle pain
- ❑ Headache
- ❑ Sore throat
- ❑ Loss of taste or smell
- ❑ Diarrhea
- ❑ Feeling feverish or a measured temperature greater than or equal to 100.0 degrees Fahrenheit
- ❑ Known close contact with a person who is lab confirmed to have COVID-19

_____ Temperature

Administration use only:

Taken by (print clearly) _____ Date taken _____

Assigned Court _____ Reservation Time_____ Supervisor Assigned _____
