JORDAN DISTRICT SUMMER PROGRAMS 2020
DAILY COVID-19 SCREENING FORM

Today's Date_____ School _____

Do you have any of the following symptoms today? (Circle YES/NO)

- Fever of 100.4 F or above YES NO
- Cough (new, undiagnosed cough) YES NO
- Trouble breathing or shortness of breath YES NO
- Sore throat YES NO
- Diarrhea YES NO
- Sudden change in taste or smell YES NO
- Muscle aches or pains YES NO
- Close contact with someone with COVID-19 YES NO

Student Name _____ Student Signature_____

CHECKLIST:

- ○ Student symptom check complete
- ○ Coach symptom check complete
- ○ Student has washed or sanitized hands
- ○ Coach has washed or sanitized hands
- ○ Coach wore face mask while doing symptom checks

By signing below, I hereby acknowledge that the above procedures have been followed and completed for identified student prior to participation. I also acknowledge that my own symptom checks have been completed prior to participating as a coach.

Coaches Name_____ Coaches Signature _____