Springfield Township High School Athletic Department
Athlete and Staff COVID-19 Screening Form

Name:_____ Date: _____

Grade:_____ Sport: _____

Students/Coaches should self report as deemed necessary prior to each practice/event. Temperature may be taken from a designated trained individual as needed. The other symptoms should be marked as “N” - NO or “Y” - Yes answers.

For the Column “Close Contact” the answer should reflect the following question: Within the past 14 days have you had close contact with someone who is currently sick with suspected or confirmed COVID-19? (Note: Close contact is defined as within 6ft for more than 10 consecutive minutes, without PPE) If the responses are “YES,” the students/coach would NOT be permitted to practice or compete and will be asked to leave school grounds. A Parent/Guardian will be notified.

DATE	TEMP	FEVER /CHILLS	COUGH	SORE THROAT	SHORT OF BREAT H	LOSS TASTE/ SMELL	VOMIT/ DIARRHEA	CLOSE CONTACT