

# COVID-19 Athlete/Coach Monitoring Form

|      |      | <b>Circle Yes/No below</b> |    |       |    |             |    |                     |    |   |    |                               |
|------|------|----------------------------|----|-------|----|-------------|----|---------------------|----|---|----|-------------------------------|
| Name | Time | Fever                      |    | Cough |    | Sore Throat |    | Shortness of Breath |    | Close contact, or cared for someone with COVID-19 |    | Temp (if higher than 100.3°F) |
|      |      | Yes                        | No | Yes   | No | Yes         | No | Yes                 | No | Yes   | No |                               |
|      |      | Yes                        | No | Yes   | No | Yes         | No | Yes                 | No | Yes   | No |                               |
|      |      | Yes                        | No | Yes   | No | Yes         | No | Yes                 | No | Yes   | No |                               |
|      |      | Yes                        | No | Yes   | No | Yes         | No | Yes                 | No | Yes   | No |                               |
|      |      | Yes                        | No | Yes   | No | Yes         | No | Yes                 | No | Yes   | No |                               |
|      |      | Yes                        | No | Yes   | No | Yes         | No | Yes                 | No | Yes   | No |                               |
|      |      | Yes                        | No | Yes   | No | Yes         | No | Yes                 | No | Yes   | No |                               |
|      |      | Yes                        | No | Yes   | No | Yes         | No | Yes                 | No | Yes   | No |                               |
|      |      | Yes                        | No | Yes   | No | Yes         | No | Yes                 | No | Yes   | No |                               |
|      |      | Yes                        | No | Yes   | No | Yes         | No | Yes                 | No | Yes   | No |                               |
|      |      | Yes                        | No | Yes   | No | Yes         | No | Yes                 | No | Yes   | No |                               |
|      |      | Yes                        | No | Yes   | No | Yes         | No | Yes                 | No | Yes   | No |                               |
|      |      | Yes                        | No | Yes   | No | Yes         | No | Yes                 | No | Yes   | No |                               |
|      |      | Yes                        | No | Yes   | No | Yes         | No | Yes                 | No | Yes   | No |                               |
|      |      | Yes                        | No | Yes   | No | Yes         | No | Yes                 | No | Yes   | No |                               |
|      |      | Yes                        | No | Yes   | No | Yes         | No | Yes                 | No | Yes   | No |                               |
|      |      | Yes                        | No | Yes   | No | Yes         | No | Yes                 | No | Yes   | No |                               |
|      |      | Yes                        | No | Yes   | No | Yes         | No | Yes                 | No | Yes   | No |                               |
|      |      | Yes                        | No | Yes   | No | Yes         | No | Yes                 | No | Yes   | No |                               |
|      |      | Yes                        | No | Yes   | No | Yes         | No | Yes                 | No | Yes   | No |                               |
|      |      | Yes                        | No | Yes   | No | Yes         | No | Yes                 | No | Yes   | No |                               |
|      |      | Yes                        | No | Yes   | No | Yes         | No | Yes                 | No | Yes   | No |                               |
|      |      | Yes                        | No | Yes   | No | Yes         | No | Yes                 | No | Yes   | No |                               |
|      |      | Yes                        | No | Yes   | No | Yes         | No | Yes                 | No | Yes   | No |                               |
|      |      | Yes                        | No | Yes   | No | Yes         | No | Yes                 | No | Yes   | No |                               |