Redline Athletics Morristown COVID-19 Screening Questionnaire

This questionnaire will be administered to each group of athletes while they wait for their session to begin.

Name: _____ Date: _____

1. **Have you been diagnosed with COVID-19 within the past 14 days?**
   o YES o NO

2. **Have you had close contact with or cared for someone who has tested positive for COVID-19 within the past 14 days?**
   o YES o NO

3. **Have you been in close contact with a suspected case of COVID-19 within the past 14 days?**
   o YES o NO

4. **Have you traveled outside of New Jersey within the past 14 days?**
   o YES o NO
   If so,
   where?:_____
   _____

5. **Are you currently experiencing, or have you experienced within the last 14 days, any of the following symptoms:**

   Fever or chills o YES o NO
   Dry cough o YES o NO
   Difficulty breathing or shortness of breath o YES o NO
   Fatigue o YES o NO
   Muscle or body aches o YES o NO
   Sore throat o YES o NO
   Headache o YES o NO
   Congestion or runny nose o YES o NO
   Nausea or vomiting o YES o NO
   Diarrhea o YES o NO

New loss of taste or smell o **YES** o **NO**

Signature:

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