COVID-19 Athlete/Coach Monitoring Form DATE: _____

Name	Time	Circle Yes/No Below										
		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	