COVID-19 Student/Director Monitoring Form

Activity:_____ Date: _____

Student Name	Coach/Screener Name	Pod #	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	
				Yes	No	Yes	No	Yes	No	Yes	No	Yes	No	
				Yes	No	Yes	No	Yes	No	Yes	No	Yes	No	