Player Name: _____ Parent Number: _____

Please Print Clearly *Required for Contact Tracing*

PARTICIPANT QUESTIONAIRE

Have you experienced a fever greater than 100 degrees in the last 5 days?

Y___ N___

Have you experienced excessive coughing/sneezing in the past 3 days*? Y___ N___

**If you answered yes to the above, is it allergy related? If yes, ok to proceed.* Y___ N___

Have you experienced shortness of breath in the past week? Y___ N___

Have you experienced loss of taste or smell at any time in the last week? Y___ N___

Have you traveled internationally or throughout the United States in the last 14 days? Y___ N___

Have you traveled within New York State to a highly infected area? Y___ N___

Has anyone in your home currently have or has had any of the symptoms referenced above? Y___ N___

Have you had close contact with anyone who has tested positive for the COVID-19 virus? Y___ N___

Have you or any member of your household been requested to self -isolate or quarantine? Y___ N___

Has your household had visitors from downstate or Western New York?

Y___ N___

If you answered yes to any of these questions*or if your answers change throughout the program, we ask that you leave the program immediately. Participant will not be allowed to return to camp until you can provide clearance by a physician.

Date: _____ Parent Signature: _____