

Player Name: _____ Parent Phone Number: _____
Please Print Clearly *Required for Contact Tracing*

PARTICIPANT QUESTIONNAIRE

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___

**If yes, where? _____*

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

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

Have you, the participant, been tested for COVID-19? Y___ N___

**If yes, what date was your test done? _____ What were the results? _____*

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. By signing this form, you attest that all provided information is true to the best of your knowledge.

Date: _____ Parent Signature: _____