PCTVS Winter Spectators

COVID-19 Screening Form

Name: _____ Date: _____

Temperature: _____

Guest List:
Player's Name & Jersey No. : _____ School: _____

Section 1: Symptoms

Please note that this list does not include all possible symptoms with COVID-19 and you may experience any, all, or none of these symptoms.

Column A

☐	Fever (measured or subjective)
☐	Chills
☐	Rigors (shivers)
☐	Myalgia (muscle aches)
☐	Headache
☐	Sore Throat
☐	Nausea or Vomiting
☐	Diarrhea
☐	Fatigue
☐	Congestion or runny nose

Column B

☐	Cough
☐	Shortness of Breath
☐	Difficult y Breathing
☐	New loss of smell
☐	New loss of taste

If TWO OR MORE of the fields in Column A are checked off OR AT LEAST ONE field in column B is checked off, please stay home and notify your doctor for further instructions.

Section 2: Close Contact/Potential Exposure

Please verify if:

☐	You have had close contact (within 6 feet of an infected person for at least 10 minutes) with a person with confirmed COVID-19
☐	Someone in your household is diagnosed with COVID-19
☐	You have traveled to an area of high community transmission.

If **ANY of the fields in Section 2 are checked off,** you should remain home for 14 days from the last date of exposure (if a close contact of a confirmed COVID-19 case) or date of return to New Jersey. Contact your local health department for further guidance