COVID-19 VISITORS SCREENING FORM

Name: _____ Date: _____
(print name)

Phone Number (for contact tracing): _____

Student-Athlete you are here to watch: _____

In the last 14 days have you had [check all that apply or "None of the above"]:

___ A positive COVID-19 diagnosis
___ Contact with someone who has symptoms or is diagnosed with COVID-19
___ A temperature of 100.4 degrees or higher
___ Cough
___ Shortness of breath/difficulty breathing
___ Chills/Repeated shaking with chills
___ Muscle pain
___ New Loss of Taste or Smell
___ Headache
___ All of the above
___ None of the above

If you have been in contact with someone that has had symptoms or tested positive for COVID-19 within the last 14 days, when was the date of exposure? _____

If you have travelled internationally within the last 14 days, please provide the date of return to the United States. _____.

If you have travelled to the impacted states identified by the State of New Jersey and pursuant to the travel advisory in the previous 14 days, please provide the date of return, and whether you complied with the self-quarantine travel advisory.
_____.

Please provide completed form to Will Taylor, Athletic Director or Glen DePino, Athletic Trainer.

The School may also screen visitors by taking a visitor's temperature. If a visitor's temperature is over 100.4 degrees, and/or if the visitor responds affirmatively to the above screening questions, the visitor may be prohibited from entering School grounds.

Action Taken:

Entry Granted _____ Entry Denied _____

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