Center State Conference Contest Assessment Form

Date: _____

Name: _____

Phone # _____

Athlete: _____

Sport: _____

Do you have any of the following symtoms?

Question 1 **In the last 10 days:** Tested positive for Covid	Question 2 **Temp over 100**	Question 3 **Symtoms:** Sore throat Headache Stomach pain no taste/smell	Question 4 **In the last 14 days:** In contact w/ anyone w/ Covid
(circle one)	(circle one)	(circle one)	(circle one)
yes / no	yes / no	yes / no	yes / no

*****NO MASK, NOT ENTRY (at school events masks required at all times)**

*****PLEASE MAINTAIN 6 FEET DISTANCE FROM OTHERS**