TEAM: _____ DATE: _____

		Does Player have? (yes or no)							
Player Name	Temp	Fever or Feeling Feverish?	Chills?	Cough?	Shortness of Breath?	Sore Throat?	Muscle Aches?	Headache?	Loss of Smell or Taste?

By signing below, I certify the information I provided on and in connection with this form is true and correct to the best of my knowledge .

Printed Name: _____ Signature: _____