LIVINGSTON
NEW JERSEY
SENIOR, YOUTH & LEISURE SERVICES

Senior, Youth and Leisure Services

COVID-19 Daily Screening Questionnaire

Name of Participant: _____ Date: _____

Parent/Guardian Cell: _____ Sport: _____

Are you experiencing any of the following symptoms? Circle YES or NO

1. Fever ≥ 100.4F	YES	NO
2. Cough or shortness of breath	YES	NO
3. Sore throat	YES	NO
4. Chills	YES	NO
5. Muscle aches of rigors	YES	NO
6. Headache	YES	NO
7. New loss of taste or smell	YES	NO
8. Abdominal pain, nausea, vomiting or diarrhea	YES	NO
9. Have you had close contact with someone who is currently sick?	YES	NO
10. Have you been diagnosed with COVID-19 in the past three weeks or have reason to believe you have COVID-19?	YES	NO
11. In the past 2 weeks have you traveled to/from a state or country that has a travel advisory requiring quarantine?	YES	NO
12. Are you currently under quarantine?	YES	NO

Parent/Guardian Signature _____ **Date:**_____