# Hendersonville Soccer Club
# Health Screening Form

**Any YES answers or symptoms CIRCLED to following questions, the player must be excluded from team activities on the date listed above**

1. Have you been in close contact with a confirmed case of COVID-19 in the past 14 days?
   (Does not apply to medical personnell, first reponders, or other individuals who encounter COVID-19 as part of their professional or caregiving duties while wearing appropriate PPE.)

   Yes ☐ No ☐

2. Does the player have any of the following symptoms that cannot be attributed to another health condition? Circle all that apply:

   a. Cough
   b. New loss of taste or smell
   c. Congestion or runny nose
   d. Shortness of breath
   e. Sore throat
   f. Fatigue
   g. Headache
   h. Diarrhea
   i. Muscle or body aches
   j. Nausea or vomiting
   k. None of the above

COACH NAME: _____ Division: _____ Date:_____

Player Name: _____ Player Name: _____

Player Name: _____ Player Name: _____

Player Name: _____ Player Name: _____

Player Name: _____ Player Name: _____

Player Name: _____ Player Name: _____

Player Name: _____ Player Name: _____

Player Name: _____ Player Name: _____

Player Name: _____ Player Name: _____

If there are any YES answers or symptoms CIRCLED to any of the above questions, the player must be excluded from team activities on the date listed above.