2021 Regional Championships
COVID19 screening form.

- Full Name *

  First Name Last Name

- School

- Temperature Reading

- Phone Number *

- Do you have any of the following symptoms?: *

  New and persistent cough Shortness of breath or any difficulty breathing
  Fever No Symptoms

- Have you been in contact with anyone in the last 14 days who is experiencing these symptoms? *

  Yes No

- Have you been in contact with anyone who has since tested positive for Covid-19? *

  Yes No Not Sure

- Do you feel well today? *