IMPACT VOLLEYBALL CLUB

315 Verona Avenue
Elizabeth, NJ 07208
www.impactvbclub.com

COVID-19 Daily Pre-screening Questions

Name of Player: ____

Parent/Guardian Cell: ____

Date: __________ / __________ / USAV AGE: 13 14 15 16 17 18 Circle one

Are you experiencing any of the following symptoms?

1.	Fever (≥ 100.4°F)	**YES**	**NO**
2.	Cough or shortness of breath	**YES**	**NO**
3.	Sore Throat	**YES**	**NO**
4.	Chills	**YES**	**NO**
5.	Muscle aches or 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**

Have you had close contact with someone who is currently sick? **YES** **NO**

Have you been diagnosed with COVID-19 in the past three weeks or have reason to believe you have COVID-19? **YES** **NO**

Have you traveled or had close contact with anyone who has traveled internationally in the last 14 days? **YES** **NO**

Temperature reading?
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To participate in tryouts, each plyer must complete this form **DAILY BEFORE EVERY EVENT**. Screening questionnaires must be completed prior to arriving to the IMPACT VB CLUB Event.