MSRA Covid-19 Symptom Screening Tool

This form is to be filled out by each member of the referee crew PRIOR to any match!
If answered "YES" to any questions 1 through 5 or "NO" to question 6 or 7, please leave the field and return home.

Date of Match: _____

Location of Match: _____

Officials Name	Time	1. Do you have a cough, shortness of breath, or sore throat?	2. Have you been in close contact with someone who has tested positive for Covid-19 within the last month.	3. Have you had vomiting or diarrhea in the last 24 hours?	4. Have you had a fever in the last 24 hours?	5. Have you recently lost your sense of taste or smell?	6. is your temperature normal today?	7. Has all of your equipment, clothing been cleaned or changed since your last day of matches?	If you are a minor, list your parent / guardian's name who answered questions.