



**EPC EVENT PERSONNEL COVID-19 SCREENING FORM**

**\*Approved 9/15/2020\***

<b>DATE:</b>	
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Today or in the past 24 hours have you had any of the following symptoms:

SYMPTOM	YES	NO
Fever? <ul style="list-style-type: none"> <li>• Temperature greater than 100.4 under age of 18</li> <li>• Temperature greater than 100.0 over age of 18</li> </ul>		
New or Worsening Cough?		
Shortness of Breath or Trouble Breathing?		
Sore Throat (that is different from your seasonal allergies)?		
New Loss of Smell or Taste or Both?		
Diarrhea or Vomiting?		
Do you have a household member or close contact who has been diagnosed with COVID-19 in the past 10-14 Days?		
Have you traveled outside of Pennsylvania in the last 14 Days? <ul style="list-style-type: none"> <li>• If Yes, where?</li> </ul>		

If you answered yes to any of the above:

- Stay Home / Go Home IMMEDIATELY.
- Student-Athletes, have your parent / caregiver go to [www.LVHN.org/videoscreening](http://www.LVHN.org/videoscreening) or <https://www.slhn.org/covid-19/feeling-sick> to receive an evaluation.
- Coaches & Event Staff, go to [www.LVHN.org/videoscreening](http://www.LVHN.org/videoscreening) or <https://www.slhn.org/covid-19/feeling-sick> to receive an evaluation.

Participant's signature below designates that this self-screening was conducted prior to reporting to campus and the information provided is true and factual to the best of participant's knowledge.

\_\_\_\_\_

Participant Printed Name

\_\_\_\_\_

Date

\_\_\_\_\_

Participant Signature

\_\_\_\_\_

Coach or ATC Signature Approved

**ATHLETIC TRAINER USE ONLY:**

<b>TEMPERATURE:</b>		<b>DATE:</b>	
<b>ATC SIGNATURE:</b>			