

## COVID-19 Game Day Pre-screening Questions

Name of Participant: \_\_\_\_\_

Cell: \_\_\_\_\_

**Are you experiencing any of the following symptoms? (Circle Yes or No)**

1.	Fever ( $\geq 100.4^{\circ}\text{F}$ )	Temperature Reading:	
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		YES	NO
Do you have any 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

**ANY YES ANSWER MEANS YOU ARE NOT ELIGIBLE TO PLAY THIS GAME**

I have answered the above questions to the best of my knowledge, and on my behalf, I hereby release, covenant not to sue, discharge, and hold harmless the United Soccer League of New Jersey (USL NJ), the Team managers, the Referees and their employees, agents, and representatives (Releasees), of and from any claims, including all liabilities, claims, actions, damages, costs or expenses of any kind arising out of or relating thereto (Claims). I understand and agree that this release includes any Claims based on the actions, omissions, or negligence of the Releasees, whether a COVID-19 infection occurs before, during, or after attending any USL NJ related soccer game.

\_\_\_\_\_  
Participant Signature

\_\_\_\_\_  
Date

Witnessed by: \_\_\_\_\_  
Team Manager Signature

\_\_\_\_\_  
Printed Name