4-H Shooting Sports National Championships

TEAM COACH & COORDINATOR

HEALTH SCREENING YOUR TEAM MEMBERS

STATE: _____

DISCIPLINE: _____

ACTIVITY DAY (CIRCLE ONE): **M** **T** **W** **TH**

Have you or any of your team members or coaches experienced any of the following symptoms in the past 24 hours?

Participants, coaches, and staff showing signs/symptoms of COVID-19 (fever over 100.4℉, sudden onset of cough or sudden onset of shortness of breath, or loss of taste of smell) shall not participate.

☐ Yes ☐ No

DATE: _____

COACH / COORDINATOR: _____

(Printed Name)

COACH/COORDINATOR: _____

(Signature)