COVID-19 HEALTH SCREENING

This section to be completed by USA Boxing member

Name: _____ Today's date: _____

Name of Event: _____

Member Type: ____Boxer ____Coach ____Official ____Admin/Volunteer

To your knowledge, in the last 10 days, have you been within 6 feet of a person for 5 minutes or longer who has been diagnosed with COVID-19?

____No ____Yes If Yes, when?_____

Have you or anyone with whom you live experienced any of the following symptoms within the last week? Check the box if YES.

YOURSELF		FAMILY/ ROOMMATE
	Fever	
	Cough	
	Sore Throat	
	Chills and or repeated shaking	
	Runny Nose or nasal congestion	
	Shortness of breath or difficulty breathing	
	Headache	
	Muscle pain/body aches	
	Severe fatigue	
	Diarrhea	
	New loss of taste or smell	
	NONE OF THE ABOVE	

If within two weeks after this event I am diagnosed with COVID-19, I will contact the USA Boxing National Office immediately at 719-866-2323. Initial here: _____

SCREENING PERSONNEL TO COMPLETE:

Temperature: _____

A secondary screen by medical personnel is required if temperature is 100.3 or higher, or if individual answered yes to any symptoms above.