



HEALTH SCREENING CHECKLIST

Have you had any of the following symptoms recently that you cannot attribute to another health condition?

Do you have? Circle yes or no:

- YES | NO Fever (100°F or higher) or feeling feverish?
- YES | NO Chills?
- YES | NO A new cough?
- YES | NO Shortness of breath?
- YES | NO A new sore throat?
- YES | NO New muscles aches?
- YES | NO New headache?
- YES | NO New loss of smell or taste?

If you have answered yes to any of the symptoms listed above, please do not enter the ballpark. Please go home and isolate yourself from others and contact your doctor for medical advice.

I sign that I am not experiencing any symptoms of COVID-19. NOTE: Legal guardians of minor children must sign in their place.

SIGNATURE

PRINTED NAME

DATE

ADDRESS, CITY, STATE, ZIP

TELEPHONE

IF SIGNING FOR A MINOR, INCLUDE THEIR NAME AND YOUR RELATIONSHIP

PLABA USE ONLY

ATTEST NAME & DATE