COVID-19 Screening Tool

Racer Name: _____

(Please print)

Circle yes or no to the following questions:

Have you received a ***positive*** COVID test within the past 14 days? **Yes** **No**

Have you been around anyone who has tested positive in the last 14 days? **Yes** **No**

Have you had any ***new or abnormal*** symptoms of COVID in the last 14 days:

Cough	**Yes**	**No**	Sore Throat	**Yes**	**No**
Shortness of breath	**Yes**	**No**	Loss of taste or smell	**Yes**	**No**
Body aches	**Yes**	**No**	Headache	**Yes**	**No**
Nausea/Vomiting	**Yes**	**No**	Diarrhea	**Yes**	**No**

_____ _____ _____

Printed Name Signature Date