WILSON SCHOOL DISTRICT

2601 Grandview Boulevard, West Lawn, PA 19609 | 610-670-0180 | wilsonsd.org

Contest Official/Gameday Staff/Media COVID-19 Screening Form

1.) In the last 14 days have you had any of the following symptoms: Fever or chills (100.0 or higher), cough, shortness of breath or difficulty breathing, fatigue, muscle or body aches, headache, new loss of taste or smell, sore throat, congestion or runny nose, nausea or vomiting, diarrhea?

YES _____________ NO _____________

If yes, please describe: ____

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If yes, did you seek medical treatment? YES ____________ NO ____________

2.) In the last 14 days have you had close contact with someone who is currently sick with suspected or confirmed COVID-19? (Note: Close contact is defined as within 6 feet for more than 10 consecutive minutes, without PPE equipment.)

YES _____________ NO _____________

If yes, please describe: ____

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If yes, did you seek medical treatment? YES ____________ NO ____________

Official/Staff Member Printed Name: ____________________________________

Official/Staff Member Phone Number: ____________________________________

Date: ____________________________________