El Segundo High School

Observer Registration & COVID-19 Screening Questionnaire

Date_____ School Name

_____ Athlete's Name

_____Sport_____

_ Observer's Name

_____

Email_____ Phone Number

_____ COVID-19 Screening Questionnaire

Have you or anyone in your household experienced any of the following symptoms in the past 48 hours? fever, chills, cough, shortness of breath, loss of taste or smell, nausea or vomiting, diarrhea, sore throat, headache, muscle or body aches or fatigue? ☐YES ☐ NO

Within the past 14 days, have you been in close physical contact (6ft or closer for a cumulative period of 15 minutes) with someone who is known to have tested positive for COVID-19, or anyone who has symptoms consistent with COVID-19? ☐YES ☐ NO

Is anyone in your household currently awaiting results of a COVID-19 test? ☐YES ☐ NO Has anyone in your household tested positive for COVID-19 in the past 10 days? ☐YES ☐ NO Have you traveled out of the state of California in the last 10 days? ☐YES ☐ NO

Signature

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