

Colchester Legion Stadium - Covid 19 Screening Form

Do you have any of the following new or worsening symptoms or signs?

New/Worsening cough	Yes	No
Shortness of breath	Yes	No
Sore throat	Yes	No
Runny nose/ sneezing nasal congestion	Yes	No
Loss of sense of smell or taste	Yes	No
Nausea/vomiting	Yes	No
Chills or sweats	Yes	No

Have you returned from travel outside of the Atlantic Bubble in the last 14 days? Yes No

Have you come into close contact with anyone who travelled outside of the Atlantic Bubble in the last 14 days? Yes No

Do you have a fever? Yes No

Have you had close contact with anyone with a respiratory illness or confirmed or probable case of Covid 19? Yes No

Name (Please print): _____

Signature: (Parent or Guardian if under 18) _____

Date: _____