U.S. JUNIOR NATIONALS

DAILY HEALTH SCREENING CERTIFICATION

THIS FORM IS REQUIRED BEFORE THE FIRST GAME OF EACH DAY

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TEAM NAME

I, the undersigned, as an authorized representative of the above named team, certify that within the last 60 minutes I have screened all of the athlete coaches, and family/spectators participating with the above named team, and attest that every athlete, coach and family/spectator has been verified to exhibit **none** of the following symptoms:

A fever in excess of 104 degrees, confirmed by infrared thermometer
Cough
Sore Throat
Congestion or runny nose
Shortness of breath or difficulty breathing
Fatigue
Muscle or body aches
Headache
Loss of taste or smell
Nausea or vomiting
Diarrhea

I also certify that I have in my possession documentation that all parties listed above have been screened.

I understand that any athlete or coach who exhibits **any** of the above listed symptoms may not participate for the duration of the event and should cease any interaction with other athletes and coaches.

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NAME OR PERSON COMPLETING THIS FORM

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TITLE (COACH, ADMINISTRATOR)

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SIGNATURE

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TIME DATE