Shore Regional Athletic Department - Spectator Health Questionnaire

Name:_____ Cell Phone:_____

Street Address:_____ Town:_____

Any of the symptoms below could indicate a COVID-19 infection. Please note that this list does not include all possible symptoms of COVID-19.

SECTION 1: Please select any of the current symptoms you may be experiencing:

☐ Fever (measured or subjective)
☐ Chills
☐ Rigors (shivers)
☐ Myalgia (muscle aches)
☐ Headache
☐ Sore Throat
☐ Nausea or Vomiting
☐ Diarrhea
☐ Fatigue
☐ Congestion or runny nose
☐ Cough
☐ Shortness of Breath
☐ Difficulty Breathing
☐ New loss of smell
☐ New loss of taste

☐ I currently am not experiencing any of the symptoms listed above.

SECTION 2: Close Contact/Potential Exposure

Please verify if in the last 14 days:

☐ You had close contact (within 6 feet of an infected person for 15 or more minutes during a 24-hour period) with a person with COVID-19

☐ Someone in your household is diagnosed with or being tested for COVID-19

☐ You have traveled from any U.S. State or territory outside of New York, Connecticut, Pennsylvania, and Delaware and is not otherwise exempt from quarantine under the DOH travel restrictions.

If ANY of the fields in Section 2 are checked off, you should remain home for 14 days from the last date of exposure (if a close contact of a confirmed COVID-19 case) or date of return to New Jersey. Contact your local health department for further guidance.

SIGNATURE:_____ DATE:_____