**Parkland Soccer Club COVID Questionnaire**

* Have you or anyone in your household had any of the following symptoms in the last 14 days: sore throat, cough, chills, body aches for unknown reasons, shortness of breath for unknown reasons, loss of smell, loss of taste, fever at or greater than 100 degrees Fahrenheit? YES or NO
* Have you or anyone in your household been tested for COVID-19 within the past 14 days? YES or NO
* Have you or anyone in your household cared for an individual who is in quarantine or is a presumptive positive or has tested positive for COVID-19? YES or NO
* Do you have any reason to believe you or anyone in your household has been exposed to or acquired COVID-19? YES or NO
* To the best of your knowledge have you been in close proximity to any individual who tested positive for COVID-19? YES or NO

IF YOU ANSWERED YES TO ANY OF THE ABOVE, PLEASE CONTACT ZOYLA ALMEIDA (zoylaalmeida@hotmail.com), or RENAY CHUNG (renaychung@hotmail.com).

Thank you,

THE PARKLAND SOCCER CLUB COVID TASK FORCE