



# Screening Assessment NYCFC Youth Programs

**PLEASE COMPLETE WITH YOUR PARENT/LEGAL GUARDIAN BEFORE EACH SESSION.**

Screening Assessment (SSA), includes:

Standardized Screening Questionnaire (if all answers **NO**, Player/staff will come to the facility. If any answers **YES**, Player/staff will not come to the facility)

Documented temperature upon entrance to facility

Standardized Screening Questionnaire (SSQ); should be completed daily and prior to coming to training each day

**IF YES TO ANY OF THE BELOW QUESTIONS, PLEASE PROVIDE DETAILS AND CONTACT YOUR YOUTH CLUBS PLAYER ADVOCATE**

Player Name

Team Name

Parent's Email Address

Today's Date

In the past 14 days, have you experienced any Covid-19 symptoms, including but not limited to: (check all that apply) \*

- No Symptoms
- Cough
- Chills or repeating shaking with chills
- Muscle Pain
- Headache
- Sore throat
- Chest pains, palpitations or fatigue
- New loss of taste or smell

Have you traveled internationally or from a location considered high risk for Covid-19 in the past 14 days?

- Yes       No

Have you been exposed in the last 14 days to anyone that has been diagnosed with Covid-19 or had Covid-19 symptoms?

- Yes       No

Is there any reason to believe that you may have been exposed to the virus in the last 14 days?

- Yes       No

Have you had a documented elevated temperature (>38° C, or 100.4° F) in the last 72 hours?

- Yes       No

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Print Parent's Name

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Parent's Signature