ACTION POTENTIAL FITNESS

Self-Assessment Form

Name: _____

Date: _____

Body Temp: _____

Yes	No	Are you currently experiencing the following symptoms?
☐	☐	Difficulty breathing, shortness of breath, and/or moderate or severe chest pain
☐	☐	A fever above 37°C (98.6°F) and/or chills
☐	☐	A cough, sore threat or painful swallowing
☐	☐	Sneezing and/or a runny nose (*not otherwise explained by seasonal allergies*)
☐	☐	Muscle or joint aches (*not otherwise explained by exercise*)
☐	☐	Nausea, vomiting, diarrhea or unexplained loss of appetite
☐	☐	Loss of sense of smell or taste
☐	☐	Conjunctivitis (*pink eye*)

Is there anything else we need to be aware of?

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