# EVENT NAME

**DATE_____**

**LOCATION _____**

| Name | Temperature | Fever >100F | Vomiting or Nausa | Diarrhea | Cough | Shortness of Breath | Difficulty Breathing | Chills | New Loss of Taste or Smell | Event Specific Form | Event Specific Form | ASI Covid Waiver | Risk Form | Commit to Transport | BSA Medical |
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