COVID-19 SCREENING FORM FOR ATHLETICS & ACTIVITIES

Complete this form to assess your potential exposure to or diagnosis of COVID-19 or other illnesses.

Name: _____ Grade: _____
Last First Middle Initial (2020-2021 School Year)

Birth Date: _____ Gender: Female Male Other
(MM-DD-YY)

Home Address: _____
Address Line City/State Zip Code

Parent/Guardian Name: _____

Contact Phone Number: _____ Email Address: _____

Questions	YES	NO
Do you have a family or household member diagnosed with the COVID-19 virus currently or in the past?		
Have you had any of the following symptoms in the past two weeks?		
• Fever		
• Cough		
• Shortness of breath or difficulty breathing		
• Shaking chills		
• Chest pain, pressure, or tightness		
• Fatigue or difficulty with exercise		
• Loss of taste or smell		
• Persistent muscle aches or pains		
• Sore Throat		
• Nausea, vomiting, or diarrhea		
Do you have moderate to severe asthma, a heart condition, diabetes, or a weakened immune system?		
Have you been diagnosed or tested positive for COVID-19 infection?		
If yes, what was date of test (MM-DD-YY)?		
If yes, during the infection, did you suffer from chest pain, pressure, tightness or heaviness, or experience difficulty breathing or unusual shortness of breath?		
If yes, since the infection, have you had new chest pain or pressure with exercise, new shortness of breath with exercise, or decreased exercise tolerance?		

****Should any of your information/answers change, notify a coach IMMEDIATELY.***

_____ _____

Student-Athlete SIGNATURE Date Parent/Guardian SIGNATURE Date