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 the school's administration IMMEDIATELY.*

_____ _____
Student-Athlete SIGNATURE Date ☒ Parent/Guardian SIGNATURE Date