COVID-19 SCREENING FORM FOR ATHLETICS & ACTIVITIES

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

Student Name: _____ Parent/Guardian Name:_____

Address: _____

City: _____ State: _____ Zip Code: _____

Parent/Guardian Phone Number: _____

2020-21 Year in School: _____

GENDER: ☐ MALE ☐ FEMALE

DOB:_____ Age: _____

Question	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?	☐	☐

COVID-19 Screening Form

Have you been diagnosed or tested positive for COVID-19 infection?

☐ YES ☐ NO DATE OF TEST: / /

If you had COVID-19 infection,

- During the infection, did you suffer from chest pain, pressure, tightness or heaviness, or experience difficulty breathing or unusual shortness of breath?
  ☐ YES ☐ NO
- Since the infection, have you had new chest pain or pressure with exercise, new shortness of breath with exercise, or decreased exercise tolerance?
  ☐ YES ☐ NO

**Should any of your information/answers change, please notify the school's administration IMMEDIATELY.*

Student-Athlete Signature: _____ Date: _____

Parent/Guardian Signature:_____ Date: _____