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:_____ Sport(s):_____

Parent/Guardian Name:_____

Address:_____

City:_____ State:_____ Zip Code:_____

Parent/Guardian Phone Number:_____

School District:_____

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?		

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: _____

SIAW Schools Insurance Association of Washington

Administered by: CLEAR risk solutions

USIP United Schools Insurance Program