Student-Athlete COVID-19 Pre-Participation Screening

Please complete this form to assess your potential exposure / possession of COVID-19 during time away from RSD.

Name: _____ Date of Birth: _____Sport(s): _____

Are you currently free from illness? ☐ Yes ☐ No

During your time away from RSH, did you experience, or are you currently experiencing any of the following:

Symptom	Yes	No	Length of Symptom	Explanation of Symptom
Fever				
Body Chills				
Extreme Level of Fatigue				
Cough				
Painful/Difficulty Breathing				
Shortness of Breath				
Sore Throat				
Body/Muscle Aches				
Loss of Taste				
Loss of Smell				
Changes to Vision/ Eye Discharge				

Close-Contact Questions	Yes	No
2-14 days prior to experiencing these symptoms, did you experience a suspected exposure to COVID-19?		
Have you had any direct contact with anyone who lives in or has visited a place where COVID-19 is spreading and/or is an area reporting an increased number of COVID-19 cases (i.e. "hot spots")?		
Have you had any direct contact with someone that has a suspected or lab confirmed case of COVID-19?		
During your time away from RSD, did you self-quarantine due to suspected symptoms or exposure of COVID-19?		
During your time away from RSD, have you been living in, or have visited an area reporting an increased number of COVID-19 cases (i.e. "hot spots")?		

Have you previously been or are you currently diagnosed with COVID-19? ☐ YES ☐ NO Diagnosis Date:_____

Do you have medical documentation to support your diagnosis and treatment of COVID-19? ☐ YES ☐ NO
PHYSICIAN NAME: _____ PHYSICIAN LOCATION: _____

Did you require hospitalization during time infected with COVID-19? ☐ YES ☐ NO ☐ N/A

Did you require treatment with oxygen? ☐ YES ☐ NO ☐ N/A

Did you require treatment with a ventilator? ☐ YES ☐ NO ☐ N/A

If student-athlete has been cleared of COVID-19, please provide copy of clearance note

Please list any countries/states/cities you have traveled to since March 15th, 2020 and the dates you were there:

1. _____ Dates: _____
2. _____ Dates: _____
3. _____ Dates: _____

Have you ever been diagnosed with any of the following medical conditions?

Condition	Yes	No	Length of Condition	Explanation of Condition
Heart Condition				
Lung Disease				
Diabetes				
High Blood Pressure				
Immunocompromised Metabolic Disorders				
Asthma				
Obesity				
Liver Disease				
Sickle Cell Disease/Trait				

Parent Signature: _____ Date: _____

Student-Athlete Signature: _____ Date: _____