

**DO NOT TURN THIS PAGE IN BEFORE YOU REPORT ON YOUR FIRST DAY OF WORKOUTS. THIS FORM NEEDS TO BE SIGNED, DATED, AND TURNED IN ON YOUR INITIAL DAY OF REPORTING TO WORKOUT.**

## **NCHSAA Initial Screening Questions for Students to Participate in Athletic Activity During COVID-19**

The NCHSAA believes it is essential to the physical, emotional, and mental well-being of students to return to athletic activity as soon as deemed safe. However, the health and safety of these student-athletes is vital. Therefore, we are requiring that all students wishing to be involved in athletics complete this form before being allowed to participate in ANY organized activity.

Answering these questions truthfully will allow all participants to receive the needed evaluation to safely return to athletics, while helping prevent other team members and coaches from being put at risk for contracting the COVID-19 virus or causing the quarantine of some individuals or possibly an entire team.

|                                                                                 |    |                                                                                                                                                                                                                                                                    |
|---------------------------------------------------------------------------------|----|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| <b>Name</b>                                                                     |    |                                                                                                                                                                                                                                                                    |
| <b>Sport</b>                                                                    |    |                                                                                                                                                                                                                                                                    |
| <b>For the questions below, please circle yes or no</b>                         |    |                                                                                                                                                                                                                                                                    |
|                                                                                 |    |                                                                                                                                                                                                                                                                    |
| YES                                                                             | NO | Since January 1, 2020 have you been told that you have had a positive test for COVID-19, <b>OR</b> have you been told by a Doctor, Physician Assistant or Nurse Practitioner that you had to quarantine (stay home) due to concern that you had COVID-19 symptoms? |
| <b>Today or in the past 2 weeks have you had any of the following symptoms:</b> |    |                                                                                                                                                                                                                                                                    |
| YES                                                                             | NO | A fever (temperature more than 100.4° Fahrenheit or 38° Celsius)?                                                                                                                                                                                                  |
| YES                                                                             | NO | Shaking chills?                                                                                                                                                                                                                                                    |
| YES                                                                             | NO | A new or worsening cough, shortness of breath or difficulty breathing?                                                                                                                                                                                             |
| YES                                                                             | NO | Racing heart, heart skipping beats or fluttering of the heart?                                                                                                                                                                                                     |
| YES                                                                             | NO | Unusual dizziness, particularly with exercise?                                                                                                                                                                                                                     |
| YES                                                                             | NO | Fatigue or difficulty with exercise?                                                                                                                                                                                                                               |
| YES                                                                             | NO | A sore throat different than associated with seasonal allergies?                                                                                                                                                                                                   |
| YES                                                                             | NO | New loss of taste or smell?                                                                                                                                                                                                                                        |
| YES                                                                             | NO | Nausea, vomiting or diarrhea?                                                                                                                                                                                                                                      |
| YES                                                                             | NO | Do you have anyone in your household who has been diagnosed with COVID-19 in the past 14 days?                                                                                                                                                                     |
| YES                                                                             | NO | Have you been in contact with anyone infected with COVID-19 in the past 14 days?                                                                                                                                                                                   |

**By signing this document, I hereby state that, to the best of my knowledge, my answers to the above questions are complete and correct.**

Signature of athlete: \_\_\_\_\_

Signature of parent/legal custodian: \_\_\_\_\_

Date: \_\_\_\_\_ (BRING A HARD COPY OF THIS PAGE TO DAY ONE OF WORKOUTS)