

BACK TO PRACTICE **Weekly Form**

TEMPERATURE: _____

STUDENT-ATHLETE CARE

TEMPERATURE: _____

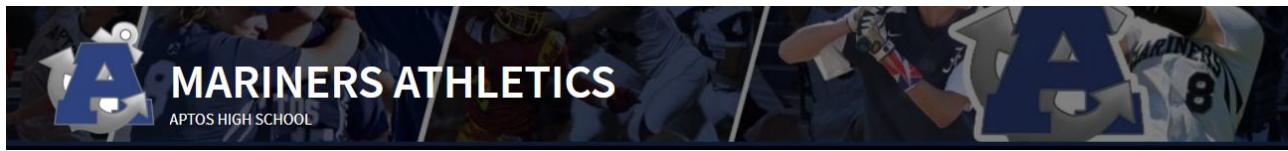
TEMPERATURE: _____

COVID-19 Student-athlete Screening Form

Instructions for use: Use one for each student-athlete practice. Ask the student-athlete these questions at the time of practice. Take the student-athlete’s temperature and note any signs of fever, coughing, or shortness of breath.

Student-athlete / Parent / Guardian Names: _____

SCREENING QUESTIONS	DATE:	DATE:	DATE:	NOTES
Do you have a fever or above-normal temperature (>100.4°F)? <i>Take temperature at practice.</i>	<input type="checkbox"/> No <input type="checkbox"/> Yes	<input type="checkbox"/> No <input type="checkbox"/> Yes	<input type="checkbox"/> No <input type="checkbox"/> Yes	<p>If student-athlete answers “yes” to either question on shortness of breath or coughing, or answers yes to any combination of two other symptoms, consider not seeing the student-athlete until symptoms resolve or until student-athlete can provide proof they are not infectious for COVID-19.</p> <p>The coach / medical staff may want to seek additional information from the student-athlete regarding symptoms.</p>
Are you experiencing shortness of breath or having trouble breathing?	<input type="checkbox"/> No <input type="checkbox"/> Yes	<input type="checkbox"/> No <input type="checkbox"/> Yes	<input type="checkbox"/> No <input type="checkbox"/> Yes	
Do you have a runny or congested nose?	<input type="checkbox"/> No <input type="checkbox"/> Yes	<input type="checkbox"/> No <input type="checkbox"/> Yes	<input type="checkbox"/> No <input type="checkbox"/> Yes	
Do you have a dry cough?	<input type="checkbox"/> No <input type="checkbox"/> Yes	<input type="checkbox"/> No <input type="checkbox"/> Yes	<input type="checkbox"/> No <input type="checkbox"/> Yes	
Have you recently lost or had a reduction in your sense of smell or taste?	<input type="checkbox"/> No <input type="checkbox"/> Yes	<input type="checkbox"/> No <input type="checkbox"/> Yes	<input type="checkbox"/> No <input type="checkbox"/> Yes	
Do you have a sore throat?	<input type="checkbox"/> No <input type="checkbox"/> Yes	<input type="checkbox"/> No <input type="checkbox"/> Yes	<input type="checkbox"/> No <input type="checkbox"/> Yes	
Are you experiencing chills or repeated shaking with chills?	<input type="checkbox"/> No <input type="checkbox"/> Yes	<input type="checkbox"/> No <input type="checkbox"/> Yes	<input type="checkbox"/> No <input type="checkbox"/> Yes	
Do you have unexplained muscle pain?	<input type="checkbox"/> No <input type="checkbox"/> Yes	<input type="checkbox"/> No <input type="checkbox"/> Yes	<input type="checkbox"/> No <input type="checkbox"/> Yes	



Do you have diarrhea?	<input type="checkbox"/> No <input type="checkbox"/> No <input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> Yes <input type="checkbox"/> Yes	
Do you have a headache?	<input type="checkbox"/> No <input type="checkbox"/> No <input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> Yes <input type="checkbox"/> Yes	
Even if you don't currently have any of the above symptoms, have you experienced any of these in the last 14 days?	<input type="checkbox"/> No <input type="checkbox"/> Yes	If "yes", do not see student-athlete unless it has been more than 10 days since symptoms first appeared and 3 days of no fever without use of fever-reducing medication.
Have you been in unprotected contact with someone who has tested positive for COVID-19 in the last 14 days? <i>"Unprotected contact" means without the use of personal protective equipment.</i>	<input type="checkbox"/> No <input type="checkbox"/> No <input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> Yes <input type="checkbox"/> Yes	If "yes", ask for the date of last contact with COVID-positive patient and set practice time for more than 14 days later.
Have you been tested for COVID-19 in the last 14 days? <i>If no, proceed to the next question.</i>	<input type="checkbox"/> No <input type="checkbox"/> Yes	
<p>If yes, what is the result of the testing?</p> <p>If negative, proceed to the next question.</p> <p>If still waiting on results, schedule practice after results are known.</p>	<input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> Positive	If positive, schedule student-athlete to return when it has been more than 10 days since symptoms first appeared and 3 days of no fever without use of fever-reducing medication.
Have you traveled more than 100 miles from your home in the last 14 days?	<input type="checkbox"/> No <input type="checkbox"/> Yes	If yes, determine if the student-athlete traveled to an area where COVID-19 cases are high. Determine if student-athlete followed physical distancing precautions and wore a mask while in public. Use professional judgement when determining whether to proceed with practice.

Student-athlete signature required at time of practice:

I agree to notify Aptos High School if within 14 days I become ill with COVID-19 symptoms or test positive for COVID-19. I understand that Aptos High School has a legal and ethical obligation to inform me if a staff person or student-athlete I had contact with tested positive for COVID-19 within 14 days.

Signature: _____ Date: _____