Cocalico School District Athletics COVID-19 

Pre-Screening Form-Student-Athlete

Name:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Date of Birth:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Incoming Grade:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Sport(s): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Please check yes or no on the following questions:

Yes\_\_\_\_\_\_ No\_\_\_\_\_ Have you or an immediate family member had a fever of 100.4 or higher in the past 14 days?

Yes\_\_\_\_\_\_ No\_\_\_\_\_ Have you or an immediate family member developed a dry cough or have had unusual shortness of breath in the past 14 days?

Yes\_\_\_\_\_\_ No\_\_\_\_\_ Have you or an immediate family member been exposed to anyone who has tested positive for COVID-19 in the past 14 days?

Yes\_\_\_\_\_\_ No\_\_\_\_\_ Have you or an immediate family member experienced any of the following symptoms: chills, repeated shaking with chills, muscle pain, headache, sore throat, loss of taste or smell, or diarrhea-in the past 14 days?

**Parent / Legal Guardian**

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Print Name Signature

**Student-Athlete**

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Print Name Signature