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.

Name		
Sport		
For the questions below, please circle yes or no		
YES	NO	Since January 1, 2020 have you been told that you have had a positive test for COVID-19, **OR** 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?
Today or in the past 2 weeks have you had any of the following symptoms:		
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: _____

In reviewing the initial screening documents, it is important to note the answers to the questions as shown above. Please note the following relative to YES answers:

Question: Since January 1, 2020 have you been told that you have had a positive test for COVID-19, OR 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?

Individuals answering "YES": **REQUIRED** to obtain, in writing ,a statement from the Doctor, Physician Assistant, or Nurse Practitioner who oversaw the COVID-19 care and is released the individual to resume full participation in athletics.

Question: Today or in the past 2 weeks have you had any of the following symptoms:

Individuals answering "Yes" to any of the questions found in the section: **REQUIRED** to see a Doctor, Physician Assistant or Nurse Practitioner (or their designee) and obtain, in writing, a statement that the student-athlete had a negative test for COVID-19 and has been released to resume full participation in athletics.

Return to Play Forms are provided for use by the students.