PRE-SEASON COVID-19 SCREENING

NWAC PRE-PARTICIPATION EXAMINATION COVID-19 ADDENDUM

To ensure the safety of all participants within the Northwest Athletic Conference (NWAC), all incoming and returning student-athletes are required to complete the following screening prior to participation in any team related activities.

THIS FORM MUST BE COMPLETED BY A MEDICAL PROVIDER WITHIN ONE OR TWO WEEKS PRIOR TO ARRIVAL ON CAMPUS. A COVID-19 TEST IS NOT REQUIRED, BUT MAY BE COMPLETED IF DETERMINED TO BE APPROPRIATE BY THE MEDICAL PROVIDER

STUDENT-ATHLETE INFORMATION

Name (Last, First MI):	
Student ID#:	**Date of Birth (MM/DD/YYYY):**
Local Address:	
Permanent Address:	
Cell Phone:	**Sex (circle one):** ☐ **Male** ☐ **Female**

COVID-19 SCREENING

Please complete the following information to assess your risk of exposure and symptom experiences related to COVID-19.

QUESTION		YES	NO
Have you been diagnosed with COVID-19?			
Do you have medical documentation to support your diagnosis and treatment of COVID-19?			
Date of Diagnosis (MM/DD/YYYY):	**Did hospitalization occur with diagnosis?**		
Physician Name/Contact Information:			
Have you been in contact with anyone diagnosed with COVID-19 in the past 14 days?			

Have you experienced any of the following symptoms in the last 14 days?

SYMPTOM	YES	NO	DATE OF LAST SYMPTOM EXPERIENCE
Fever			
Extreme Fatigue			
Dry Cough			
Shortness of Breath			
Body/Muscle Aches			
Loss of Taste of Smell			
Pain or Difficulty Breathing			

I certify that I have provided true and accurate information to the best of my knowledge.

Student-Athlete Signature: _____ Date: _____

MEDICAL PROVIDER EVALUATION

Cardiac History/Symptom Review	☐ Normal	☐ Abnormal	
Respiratory History/Symptom Review	☐ Normal	☐ Abnormal	
Is this individual at high risk for complications?	☐ Yes	☐ No	
Has the individual been tested for COVID-19	☐ Yes	☐ No	Date Completed:
Additional Notes/Recommendations:			

Do you recommend further COVID-19 or follow up testing (EKG/PFT)? ☐ No ☐ Yes

Student-athlete is: ☐ Not cleared for participation until follow up complete

- OR - ☐ Cleared to return to participation in accordance with the institutions return to activity

Medical Provider Name _____Medical Provider Phone: _____

Medical Provider Signature: _____ Date: _____

ACKNOWLEDGEMENT

In the interest of health and public safety during the COVID-19 pandemic, I acknowledge that I have truthfully and accurately disclosed the above information regarding my health status, including any symptoms and exposure to COVID-19 in order for INSTITUTION to evaluate before allowing my return to campus. I further acknowledge that, if additional evaluation or assessment is required and requested by the institution, I hereby consent and will cooperate.

In addition, if any of the symptoms mentioned above appear after I am allowed to return to campus, I agree to stay at home and to immediately report my change in status to the proper medical authorities at the INSTITUTION and to complete a new Assessment, Acknowledgement and Consent form for approval before returning to campus. At all times while on campus, I agree to follow all safety protocols and social distancing guidelines established by INSTITUTION, the City of _____, _____ County, and the State _____.

Student--Athlete Signature: _____ Date: _____

Parent/Guardian Signature: _____ Date: _____

Signature may be that of a student or athlete over 18 years of age.
If under 18, this form must be signed by the Parent or Guardian.