Elizabethtown Area School District
Athlete Pre-workout Screening

Student Name: _____ Date: _____

Temperature: _____

1a. In the last 7 days have you had any of these new symptoms: cough or shortness of breath or difficulty breathing, or fever?

No_____ Yes _____

If “NO”, move to question #1b.
If “YES” to at least one symptom, follow steps outlined in the Athletic Health and Safety Plan for what to do if you are sick.

1b. In the last 7 days have you had at least two of these new symptoms: shaking with chills, muscle pain, headaches, sore throat, loss of taste or smell, or diarrhea*? (*Diarrhea: >3 loose or liquid stools/day)

No _____ Yes _____

If “NO” move to question #2.
If “YES” to at least 2 symptoms, follow steps outlined in the Athletic Health and Safety Plan for what to do if you are sick.

2 . In the last 14 days, have you been in personal contact with someone with suspected or confirmed COVID-19 or do you have a pending COVID-19 test?

No _____ Yes _____

If “NO”, may proceed. If “YES” follow steps outlined in the Athletic Health and Safety Plan for what to do if you are sick.

I certify that the information above is true and correct to the best of my knowledge.

Parent/Guardian Signature: _____