COVID-19 Health Disclosure

This form is to be completed by all sports team members prior to participation in team activities.

Personal Information

Full Name

Team

Date

Symptom Check

In the past 14 days, have you experienced any of the following symptoms?

☐ Fever ☐ Cough ☐ Shortness of breath ☐ Loss of taste or smell ☐ None

Exposure History

Have you had close contact with anyone diagnosed with COVID-19 in the past 14 days?

○ Yes ○ No

Travel History

Have you traveled internationally or to any COVID-19 hot spots within the last 14 days?

○ Yes ○ No

Additional Comments or Details

Signature

Date