UNIVERSITY of MINNESOTA DULUTH SPORTS MEDICINE

Camper COVID-19 Screening

Name: ______________________________Sport(s): _____________Date of Birth: _____________ Age: _____ Gender: ______

Please complete this form to assess your potential exposure / possession of COVID-19 and other illnesses.

Are you currently free from illness? ▢ Yes ▢ No

In the last 14 days have you experienced or are you currently experiencing any of the following:

SYMPTOM	YES	NO	DATE SYMPTOM STARTED	EXPLANATION
Fever				
Body Chills				
Extreme Level of Fatigue				
Cough				
Pain / Difficulty Breathing				
Shortness of Breath				
Sore Throat				
Body / Muscle Aches				
Loss of Taste				
Loss of Smell				
Other				

QUESTION	YES	NO	If Yes, please provide dates or additional requested information:
Have you had any direct contact with anyone who has symptoms of COVID-19?			
Have you had any direct contact with someone who has a lab confirmed case of COVID-19?			
During your time away from UMD, did you quarantine due to suspected symptoms of or exposure to COVID-19?			

Have you previously been or are you currently diagnosed with COVID-19?

▢ YES ▢ NO DATE OF DIAGNOSIS: _____/_____/_____

IF YES, Do you have medical documentation to support your diagnosis and treatment of COVID-19? If yes

▢ YES ▢ NO PHYSICIAN NAME: ____

PHYSICIAN LOCATION: ____________________________________

Student-Athlete Signature: _______________________________________ Date: ________________________

Parent Signature (if under 19): ______________________________________ Date: ________________________

Contact Phone Number: ____