COVID-19 RISK INFORMED CONSENT

I, _____ (club member or guest name), understand that the novel coronavirus, COVID-19, has been declared a worldwide pandemic by the World Health Organization. I further understand that COVID-19 is contagious and is believed to spread by person-to-person contact; and, as a result, federal and state health agencies recommend social distancing. I recognize that are closely monitoring this situation and have put in place reasonable preventative measures aimed to reduce the spread of COVID-19. I hereby acknowledge and assume the risk of becoming infected with COVID-19 through my participation in club activities on and off water.

I understand that, if I have a COVID-19 infection, and even if I do not have any symptoms for the same, proceeding with club activities can lead to a higher chance of complication and spread of the infection to those around me, including family and friends.

I understand that possible exposure to COVID-19 may result in the following: a positive COVID-19 diagnosis, extended quarantine/self-isolation, additional tests, and I may need additional care that may require me to go to an emergency room or a hospital.

I understand all the potential risks, including but not limited to the potential short-term and long-term complications related to COVID-19, and I would like to proceed with participation in athletic competition.

I UNDERSTAND THE EXPLANATION ABOVE, HAVE NO FURTHER QUESTIONS, AND CONSENT TO PARTICIPATION IN ATHLETIC ACTIVITIES FREELY

_____ _____ _____

Member/guest Signature Date Time

Member/Guest Participant Pre Participation
COVID-19 Screening

Name: _____
Last First Middle Initial

Address _____ _____ _____
and Street City State ZIP

Cell Phone #: _____

Gender: ☐ Male ☐ Female Member ____ or Guest ____

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

Are you currently free from illness? ☐ Yes ☐ No HAVE YOU BEEN VACINATED for COVID? ☐ Yes ☐ No

Have you experienced, or are you currently experiencing any of the following:

SYMPTOM	YES	NO	LENGTH OF SYMPTOM	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	☐	☐		
Changes to Vision / Eye Discharge	☐	☐		

	YES	NO
2-14 days prior to experiencing these symptoms, did you experience a suspected exposure to COVID-19?	☐	☐
Have you had any direct contact with someone that has a suspected or lab confirmed case of COVID-19?	☐	☐
Did you self-quarantine due to suspected symptoms or exposure of COVID-19?	☐	☐
Have you been living in, or have visited an area reporting an increased number of COVID-19 cases (i.e. "hot spots")?	☐	☐

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

☐ Yes ☐ No DATE OF DIAGNOSIS : _____

If response to above questions is Yes - Do you have medical documentation to support your diagnosis and treatment of COVID-19? ☐ Yes ☐ No **Please provide a copy of clearance certificate**

Please list any countries / states / cities you have traveled to since March 15th, 2020 and the dates you were there:

1. _____ Dates: _____
2. _____ Dates: _____
3. _____ Dates: _____
4. _____ Dates: _____
5. _____ Dates: _____

Participant Signature: _____ Date: _____