



PARTICIPANT INFORMATION

Name: _____ **Association Name:** _____ **Team:** _____

Have you been in close contact to a person who is lab–confirmed to have COVID-19 in the past 14 days?
 ___ Yes ___ No
If yes, what was the date of the last known close contact?

COVID-19 DISCLOSURE, ACKNOWLEDGMENT & WAIVER

Are you exhibiting any of the following new or worsening symptoms of possible COVID-19?

- ___ Cough
- ___ Shortness of breath or difficulty breathing
- ___ Chills
- ___ Repeated shaking with chills
- ___ Muscle Pain
- ___ Headache
- ___ Sore throat
- ___ Loss of taste or smell
- ___ Diarrhea
- ___ Feeling Feverish or a measured temperature greater than or equal to 100 degrees Fahrenheit
- ___ Known close contact with a person who is lab confirmed to have COVID-19
- ___ Currently living with someone experiencing symptoms of COVID-19
- ___ None of the above/No Symptoms

Temperature certification:
 ___ I certify that I took my temperature before arriving at the field today and it was less than 100° F

Duty to Inform:
 ___ I will inform you if I knowingly come in contact with someone who tested positive within 14 days prior.
 ___ I will inform you and not attend Pop Warner activities for 14 days if I develop any of the above symptoms.
If I test positive for COVID-19, I will not return to Pop Warner activity without medical clearance.

COVID-19 has been declared a worldwide pandemic by the World Health Organization. **COVID-19 is extremely contagious** and is believed to spread from person-to-person contact. Federal, state, and local governments and health agencies recommend social distancing and have, in many areas, prohibited group activities.

Pop Warner is taking steps to reduce the spread of **COVID-19**; however, Pop Warner **cannot guarantee** that you or your child(ren) will not become infected with **COVID-19**. Further, **attending Pop Warner activity could increase** the risk of contracting **COVID-19**.

By signing this agreement, I acknowledge the contagious nature of **COVID-19** and voluntarily assume the risk that my child(ren) and I may be exposed to or infected by **COVID-19** by attending Pop Warner activity and that such exposure or infection may result in personal injury, illness, permanent disability, and death. I understand that the risk of becoming exposed to or infected by **COVID-19** may result from the act, omission, or negligence of myself and others, including, but not limited to, Pop Warner volunteers, and other participants and their families.

I voluntarily agree to assume the foregoing risks and accept sole responsibility for any injury to my child(ren) or myself (including, but not limited to, personal injury, disability, and death), illness, damage, loss, claim, liability, or expense, of any kind, that I or my child(ren) may incur by reason of Pop Warner activity (“Claims”). On my behalf, and on behalf of my children, I hereby release and covenant not to sue Pop Warner, its affiliated organizations, employees, volunteers, agents, and representatives, of and from the Claims.

SIGNATURES

Participant Signature: _____ **Date:** _____ **Parent Signature:** _____

Witness: _____ **Witness:** _____