

Date:

COVID QUESTIONNAIRE FOR YOUNG ATHLETES

Print out this form and look at the video before entering your answers.
 All questions contained in this questionnaire are strictly confidential and can become part of your medical record.

Since we are in a Pandemic, your Pre Participation exam (PPE) must include questions regarding whether you have had COVID-19 or been exposed. The SARS-Coronavirus-2 (COVID-19) infection can cause damage to your heart (myopericarditis) even if you've only had minor exposure and not had any complaints or symptoms. Screening for active or prior infection, with appropriate work up could prevent life threatening consequences during or after physical activity. Please complete this questionnaire and give it to your Doctor, coach or trainer.

Name <i>(Last, First, M.I.):</i>	<input type="checkbox"/> M <input type="checkbox"/> F	DOB:
Weight:	Height:	
Sport(s):		
Previous or referring family doctor:	School:	

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Have you come into contact with someone diagnosed with COVID-19 in the past 2 weeks?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Have you come in contact with individuals who were sick with coughing, sneezing, febrile or other symptoms of a viral disease in the past 2 weeks?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Have you had a positive COVID-19 test or diagnosed as having COVID-19 by your Doctor?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
In the past 2 weeks, have you attended events occurring indoors with more than 6 people participating?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Check off any of these exposures: <input type="checkbox"/> Playing basketball, volleyball or other indoor sport <input type="checkbox"/> Church <input type="checkbox"/> Concerts <input type="checkbox"/> Political rallies or demonstrations		
In the past 2 weeks, have you had any of the following?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Check off any of these symptoms/complaints: <input type="checkbox"/> Fever or feeling feverish (chills, sweating) <input type="checkbox"/> Cough <input type="checkbox"/> Shortness of breath or difficulty breathing <input type="checkbox"/> Fatigue <input type="checkbox"/> Muscle or body aches <input type="checkbox"/> Headache <input type="checkbox"/> New loss of taste or smell <input type="checkbox"/> Sore throat <input type="checkbox"/> Congestion or runny nose <input type="checkbox"/> Nausea or vomiting <input type="checkbox"/> Diarrhea		
If you answered yes to any of the above, please reach out to your medical provider for further guidance.		

