COVID-19 SUPPLEMENTAL ATHLETICS QUESTIONNAIRE

STUDENT NAME:______________________ **GRADE**_____ **SPORT**____________

Has/Does your child:		
COVID-19 Supplemental Questionnaire	**Yes**	**No**
2. Have you had any of the following in the past 2 weeks? ☐ Fever ☐ Cough ☐ Shortness of breath or difficulty breathing ☐ Shaking chills ☐ Chest pain, pressure or tightness ☐ Fatigue or difficulty with exercise ☐ Loss of taste or smell ☐ Persistent muscle aches or pains ☐ Sore throat ☐ Nausea, Vomiting or Diarrhea		
3. **Do you have a family or household member with current or past COVID-19?**	YES	NO
4. **Do you have moderate to severe asthma, a heart condition, diabetes, pre-existing kidney disease or a weakened immune system?**	YES	NO
5.**Have you been diagnosed or tested positive for COVID-19 infection?**	YES	NO
6.**If you had COVID-19:** A. During the infection did you suffer from chest pain, pressure, tightness or heaviness, or experience difficulty breathing or unusual shortness of breath? B. Since the infection, have you had new chest pain or pressure with exercise, new shortness of breath with exercise, or decreased exercise tolerance	YES	NO

PARENT/GUARDIAN SIGNATURE:_________________________
DATE:_______________