

Whole Child Physical Participation COVID-19 Questionnaire

Child's Full Name

Date of Birth (MM/DD/YYYY)

Have you been diagnosed with COVID-19 in the last 12 months? Yes No

If the answer is **NO**, you do not need to answer the questions below. Please have your parent sign and date the form below.

If the answer is **YES**, when were you diagnosed? _____

Date (MM/DD/YYYY)

What was it like for you to have COVID-19? Answer the questions below with help from your parent or guardian.

Did you have fever while you were sick with COVID-19? Yes No

If the answer is **YES**, how many days did you have fever? Less than 4 days Greater than 4 days

Did you have shortness of breath (feeling like someone was sitting on your chest and you couldn't breathe) while you were sick with COVID-19? Yes No

Did you have chest pain while you were sick with COVID-19? Yes No

Did you have pneumonia while you were sick with COVID-19? Yes No

Were you hospitalized while you were sick with COVID-19? Yes No

Were you diagnosed with Multisystem Inflammatory Syndrome in Children (MIS-C) while infected with COVID-19 or in the weeks or months following your illness? Yes No

*For parents/guardians only: I certify that I have reviewed the answers to this document with my child and confirm the answers to be correct.

Parent/Guardian Printed Name

Date (MM/DD/YYYY)

Parent/Guardian Signature