Goodside Health

SPORTS PARTICIPATION COVID-19 QUESTIONNAIRE

Athlete's Full Name:_____ Date of Birth:_____

Have you ever been diagnosed with COVID-19? 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? _____

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_____

**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's Full Name: Print Parent's Signature Date