For Office Use
Provider's Initials: ______

COVID QUESTIONNAIRE FOR SPORTS

Please complete the following if you've had a full wellness exam within the last 6 months and need a sports form signed.

Name of Child:____ Date of Birth:____________________

Check "YES," "NO," or "UNSURE" for the following questions. Explain all "YES" responses in the space provided below.

	YES	NO	UNSURE
1. Have you ever had confirmed or suspected COVID-19 infection?			
a. Did you have 4 or more days of fever, muscle aches, or fatigue?			
b. Did you have other symptoms?			
c. Were you hospitalized?			

Explain all "YES" responses here:

____ ____________________

Patient Name Today's Date

____ ____

Signature of patient or parent/guardian if patient is under 18 Parent/Guardian Name & Relationship to Patient

By typing your name in the signature field, you confirm that the information provided above is accurate to the best of your knowledge and authorize disclosure of the requested information.

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