MedStar Health

COVID-19 Screening

Name: ____

Date of Birth:____________________**Age:**__________**Cell Phone:** ________________________

Have you previously been or are you currently diagnosed with COVID-19? ▢ YES ▢ NO DATE: ____/___/______

Do you have medical documentation to support your diagnosis and treatment of COVID-19? ▢ YES ▢ NO

How were you diagnosed positive for COVID-19?

▢ PCR TEST ▢ ANTIGEN TEST ▢ UNKNOWN / UNSURE WHAT TEST

▢ PRESUMED POSITIVE (typical symptoms after known contact)

Were you hospitalized for COVID-19? ▢ YES ▢ NO **HOSPITAL and DATES**:______________________________

During your diagnosis, did you experience or are you currently experiencing lingering symptoms:

SYMPTOM	YES	NO	LENGTH OF SYMPTOM	EXPLANATION or LINGERING SYMPTOMS?
Fever or Chills				
Nausea or Vomiting				
Extreme Level of Fatigue				
Cough				
Pain / Difficulty Breathing				
Shortness of Breath				
Sore Throat				
Body / Muscle Aches				
Loss of Taste or Smell				
Headache				
Other: please explain				

QUESTIONS	YES	NO
Were you evaluated by a physician before returning to exercise?		
Were you given any exercise restrictions? If yes, please explain:		
Have you had any advanced testing? (Blood Work, Echo, EKG, MRI, OTHER) If yes, please explain:		
Do you currently experience any shortness of breath, dizziness, or palpitations during exercise? If yes, please explain:		
Have you been vaccinated for COVID-19? ▢ MODERNA Dose 1: __________ Dose 2: _________ ▢ PFIZER Dose 1: __________ Dose 2: _________ ▢ J&J Dose 1: __________		
If you are not vaccinated, do you have a medical or religious exemption?		

Athlete Signature:____ **Date:** ____________________

Parent Signature (if athlete under 18):_________________________ **Date:** ____________________