Springfield Public Schools Post COVID-19 Questionnaire

Name:______________________________ Date:_______________________________

Sport:______________________________

The purpose of this form is to assess the student athlete's health after having COVID-19. This form can be filled out after the student athlete completes their 5 day isolation period. The student must show improvement in symptoms and be fever free (100.4 F or less with NO fever reducing medications) in the past 24 hours.

If you have any "Yes" answer please explain on the lines below

1. **How were your COVID-19 symptoms? (check one)**

   __Asymptomatic or Mild (Less than 4 days of fever, less than 1 week of aches, chills, or sluggishness)

   __Moderate (more than four days of fever, more than 1 week of aches/chills/ sluggishness, OR admitted to the hospital)

   __Severe (had to stay in the ICU, had to have a tube to help you breathe, OR were diagnosed with MIS-C)

2. **Have you ever experienced chest pain/ discomfort/ tightness/ pressure related to exercise?**

   __Yes __No

3. **Have you ever experienced lightheadedness or feeling like "you're going to pass out" from exercise?**

   __Yes __No

4. **Have you ever experienced heart palpitations or extreme difficulty breathing with exercise?**

   __Yes __No

5. **Do you have a history of a heart murmur?**

   __Yes __No

6. **Do you have a history of high blood pressure?**

   __Yes __No

7. **Have you ever been restricted from participating in sports before?**

   __Yes __No

8. **Have you ever had prior testing for the heart before, ordered by a physician?**

   __Yes __No

9. Has anyone in your family died suddenly or unexpectedly before the age of 50 due to heart disease?

    __Yes __No

10. Has anyone in your family had a disability from heart disease before the age of 50?

    __Yes __No

Please explain any YES answers below:

I certify that all answers above were answered to the best of my knowledge

Parent/ Guardian signature (If under 18) **Date**

Student Athlete signature **Date**

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PCP Recommendation based on questionnaire

__Cleared to begin gradual return to play protocol

__Need a telehealth appointment before starting graduated return to play protocol

__Need an in-person physical screening before starting graduated return to play protocol

Signature of Physician **Date**

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Name of Physician (please print)