Henry Ford Allegiance Health
Student-Athlete COVID-19 Questionnaire

The goal of Henry Ford Allegiance Health Sports Medicine team is to always place the health and safety of the athletes in our community as our priority. Currently, there is still little research on the effects that COVID-19 has on the long-term health of an athlete. Please provide the following information so we can provide the best care for your student-athlete should they experience complications secondary to a history with COVID-19 while participating in athletics.

Name: _____ Grade: _____ Sport: _____

1. Have you had any of the following symptoms in the past 2 weeks?
   Please circle:
   -Fever *-Cough* *-Shortness of breath/difficulty breathing*
   -Shaking/chills *-Sore throat* *-Chest pain/pressure/tightness*
   -Loss of taste/smell *-Nausea/vomiting/diarrhea* *-Persistent Muscle aches/pains*
   -Fatigue/difficulty with exercise

   If yes to any symptoms above, indicate date: _____

2. Have you had any of the following symptoms since January 2020 to today?
   Please circle:
   -Fever -Cough -Shortness of breath/difficulty breathing
   -Shaking/chills -Sore throat -Chest pain/pressure/tightness
   -Loss of taste/smell -Nausea/vomiting/diarrhea -Persistent Muscle aches/pains
   -Fatigue/difficulty with exercise

   If yes to any symptoms above, indicate date: _____

3. Do you have a family or household member with current or past COVID-19? **Yes / No**

4. Do you have moderate to severe asthma, a heart condition, diabetes, pre-existing kidney disease, or a weakened immune system? **Yes / No**

5. Have you been diagnosed or tested positive for COVID-19 infection? **Yes / No**

6. Have you ever had to self-isolate due to presumptive COVID-19? **Yes / No**

7. If you had COVID-19:

   a. During the infection did you suffer from chest pain, pressure, tightness or heaviness, or experience difficulty breathing or unusual shortness of breath? **Yes / No**
   b. Since the infection, have you had new chest pain or pressure with exercise, new shortness of breath with exercise, or decreased exercise tolerance? **Yes / No**

OVER

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1. *If athlete answers yes to questions #1,5 and 6= send for automatic referral to their Healthcare Provider. Parents should be notified and document below.*

2. *If athlete answers yes to question #2 closely monitor. (Recommended that AT keeps list of all athletes who answered yes to #2 to assist with monitoring)*

Documentation: *AT's should document that parent was notified of HFAH Sports Medicine's recommendation for referral to healthcare provide.*

*Date:*_____ *Time:*_____

*I have spoken with the parent/guardian of*_____

_____*Parent has agreed to follow-up with healthcare provider, and will provide release for participation.*

_____*Parent refuses recommendation for follow-up with healthcare provider.*

_____

Athletic Trainer Signature