South Lake Pediatrics

Coronavirus /COVID- 19
Physical / Sports Physical Questionnaire

Patient Name: _____ DOB: _____

1) Has the above-named patient had a positive test for Covid-19? **YES** **NO**

If yes, did child have any of the following symptoms during the time of Covid infection? (Please circle YES or NO)

- fever >2 days **YES** **NO**
- cough > 3 days **YES** **NO**
- shortness of breath /difficulty breathing **YES** **NO**
- fatigue >3 days **YES** **NO**
- chest pain **YES** **NO**
- hospitalization **YES** **NO**
- abnormal heart tests (EKG, chest Xray, echocardiogram) **YES** **NO**
- Other-_____

Patient / Parent or Guardian signature: _____

Today's Date: _____