TOUCHPOINT PEDIATRICS, P.A.

Covid-19 and Pre-sports Participation Screen

Patient Name: _____ DOB: _____

1. Has the patient ever taken a Covid-19 PCR test? If yes, when was the month/year of last PCR test?
____ No____ Yes._____

2. Has the patient ***EVER*** been diagnosed with Covid-19?
_____ No. If No, skip to question 8. _____Yes. If yes, when was the month/year of diagnosis? _____

3. Has the patient ever been hospitalized for Covid-19?
_____ No_____ Yes. If yes, where/when? _____

4. If the patient was diagnosed with Covid-19, please tell us the symptoms

_____ Asymptomatic/No symptoms
_____ Loss of taste/smell
_____ Headache
_____ Sore throat
_____ Nasal congestion/runny nose
_____ Cough
_____ Abdominal Pain
_____ Vomiting
_____ Diarrhea
_____ Rash
_____ Fever/chills
_____ Muscle aches
_____ Shortness of breath/trouble breathing
_____ Chest pain/tightness
_____ Palpitations
_____ Feeling faint/passing out
_____ Dizziness
_____ Fatigue requiring bedrest
_____ Other. Explain _____

5. If patient was diagnosed with Covid-19, did symptoms last more than 3-5 days?
_____ No_____ Yes. Please explain _____

6. Did patient have an ECG after COVID-19 diagnosis?
_____ No_____ Yes. Please explain _____

7. Please check if patient currently has any of the following symptoms *related to a previous diagnosis* of Covid-19?
_____ None
_____ Chest pain/tightness
_____ Shortness of breath/trouble breathing
_____ Unexplained fatigue requiring bedrest
_____ Palpitations (unusual heart beats)
_____ Dizziness
_____ Feeling faint/passing outs
_____ Inability/difficulty doing physical tasks that you could easily do before
_____ Swollen feet/legs or eyelids
_____ Unexpected weight gain/loss

8. Has the patient received the Covid-19 vaccines?
_____ No_____ Yes- If yes, **please make sure we have documentation on file**.

In signing below, I acknowledge that to the best of my knowledge, the above information is true and accurate.

Parent Printed Name	*Parent Signature*	*Date*

8.17.23

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