BLUE FISH
PEDIATRICS
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COVID-19 Sports Screen

If your child is 12 years or older and has been diagnosed with COVID-19, please answer the following questions. If you answer "**YES**" to any of the questions, please call the office to set up an appointment for COVID clearance. If you answer "NO" to all the questions, please email this form to our office and our medical staff will reach out to you in regards to a COVID clearance form.

Patient Name: ________________________________ Date of Birth: _____________________

Symptom Start Date/Positive Test Date (if no symptoms): _________________

1. Did you have more than three days of fever >100.4? **YES** NO
2. Did you have more than 6 days of achiness, chills, or fatigue? **YES** NO
3. Did you have any of the following:
   a. Chest pain **YES** NO
   b. Shortness of breath out of proportion to URI symptoms **YES** NO
   c. New-onset-palpitations **YES** NO
   d. Fainting **YES** NO