THE ACADEMY OF THE HOLY CROSS
DAILY SYMPTOM QUESTIONNAIRE

Student-Athlete COVID-19 Screening

Name: _____ _____ _____

Last **First** **Middle**

Date of Birth: _____ Age: _____ Cell Phone: _____

(MM/DD/YYYY)

Sport(s): _____

Please complete this form to assess your potential exposure / possession of COVID-19 and other illnesses.

Are you currently free from illness? Yes No

During your time away from Holy Cross, did you experience, or are you currently experiencing any of the following:

SYMPTOM	YES	NO	LENGTH OF SYMPTOM	EXPLANATION
Fever				
Body Chills				
Extreme Level of Fatigue				
Cough				
Pain / Difficulty Breathing				
Shortness of Breath				
Sore Throat				
Body / Muscle Aches				
Loss of Taste				
Loss of Smell				
Changes to Vision / Eye Discharge				

QUESTION	YES	NO
2-14 days prior to experiencing these symptoms, did you experience a suspected exposure to COVID-19?		
Have you had any direct contact with anyone who lives in or has visited a place where COVID-19 is spreading and/or is an area reporting an increased number of COVID-19 cases (i.e. "hot spots")?		
Have you had any direct contact with someone that has a suspected or lab confirmed case of COVID-19?		
During your time away from Holy Cross, did you self-quarantine due to suspected symptoms or exposure of COVID-19?		
During your time away from Holy Cross, have you been living in, or have visited an area reporting an increased number of COVID-19 cases (i.e. "hot spots")?		

Have you previously been or are you currently diagnosed with COVID-19?

☐ YES ☐ NO DATE OF DIAGNOSIS: _____/_____/_____

Do you have medical documentation to support your diagnosis and treatment of COVID-19?

☐ YES ☐ NO PHYSICIAN NAME: _____

PHYSICIAN LOCATION: _____

Please list any countries/states/cities you have traveled to since March 15th, 2020 and the dates you were there:

1. _____ Dates: _____
2. _____ Dates: _____
3. _____ Dates: _____
4. _____ Dates: _____
5. _____ Dates: _____

Parent/Guardian Signature: _____ Date: _____