

## USA Triathlon Athlete Medical COVID-19 Questionnaire

The COVID questionnaire is to assist athletes in self-screening for possible symptoms of or significant exposure to COVID-19. If you respond in the affirmative to any components of this questionnaire, you are at risk for acting as an asymptomatic COVID carrier or developing further COVID symptoms. Before considering competing in a mass participation event, we strongly advise you seek formal medical evaluation and possible COVID testing before traveling to this event. As some individuals may have no symptoms for a short period after COVID exposure, the questionnaire will be re-circulated and participants' temperatures will be screened before the event on-site prior to being admitted to the venue.

This questionnaire should be completed twice in the two weeks prior to your event. First, 14 days pre-event and again 24-48 hours pre-event.

### Contact History - Check all that apply:

- Had close contact with anyone diagnosed as having COVID-19?
- Provided direct care for COVID-19 patients?
- Visited or stayed in a closed environment with any patient having COVID-19?
- Worked together in close proximity, or shared the same working environment with a COVID-19 patient?
- Traveled together with COVID-19 patient in any kind of vehicle?
- Traveled internationally?  
If so, where? \_\_\_\_\_
- Lived in the same household as a COVID-19 patient?
- Been in quarantine?
- Tested positive to the swab PCR test? (as ordered by a medical professional)

### Symptoms - check any you have experienced now and in the previous 14 days

- |   |                        |
|---|------------------------|
| Fever   | Congestion/Coryza      |
| Cough   | Headache               |
| Fatigue                                       | Chills                 |
| Dyspnea (breathlessness)                      | Nausea/Vomiting        |
| Myalgia (muscle aches not just from exercise) | Diarrhea               |
| Sore Throat                                   | Loss of smell or taste |
| Chest Pain                                    |                        |

### Pre-Existing Illnesses - Check all that apply to you

- Cardiovascular Disease
- Respiratory Disease including Asthma
- Diabetes
- Immunocompromised

Name \_\_\_\_\_  
Phone \_\_\_\_\_  
Email \_\_\_\_\_  
Date filled out \_\_\_\_\_