PENNSYLVANIA STATE ATHLETIC COMMISSION
COVID-19 Medical Questionnaire

**Staff/Spectators

Full name and E-MAIL ADDRESS (PRINT)

WHICH CITIES, STATES AND COUNTRIES HAVE YOU VISITED IN THE LAST 14 DAYS? (LIST ALL)

HAVE YOU HAD ANY CONTACT WITH ANYONE WITH A RESPIRATORY DISEASE IN THE PAST 14 DAYS? (CIRCLE ONE)		DO YOU HAVE FAMILY AND/OR FRIENDS WITH OR WHO ARE SUSPECTED OF HAVING COVID-19? (CIRCLE ONE)	
Yes Details:	No	Yes Details:	No

DID ANY OF YOUR FAMILY OR FRIENDS HAVE CONTACT WITH ANYONE WITH OR WHO IS SUSPECTED OF HAVING COVID-19? (CIRCLE ONE)		HAVE YOU BEEN TESTED FOR COVID-19? (CIRCLE ONE)	
Yes Details:	No	Yes Details:	No

HAVE YOU BEEN DIAGNOSED WITH COVID-19? (CIRCLE ONE)

Yes Details:	No

HAVE YOU HAD ANY OF THE FOLLOWING IN THE PAST 14 DAYS? (CIRCLE ALL THAT APPLY)

Breathing difficulty	Cough	Loss of smell and/or taste
Headache/Muscle ache	Joint pain	Sore throat
Nausea/Vomiting/Diarrhea	Eye discomfort	Nasal congestion/Runny nose
Fatigue/Malaise	Chest pain	Fever/Chills

Declaration: I declare under penalty of perjury under the law of the Commonwealth of Pennsylvania that the foregoing is true and correct. I realize that any intentional misrepresentation may result in immediate or subsequent disqualification.

Signature _____ Date _____

Printed Name _____ City and State _____