PENNSYLVANIA STATE ATHLETIC COMMISSION

COVID-19 Medical Questionnaire

FIGHTERS NAME (AS PER PASSPORT)-PRINT				
DATE OF BIRTH			GENDER (CIRCLE ONE)	
Month	Day	Year		
			Male	Female
EMAIL ADDRESS				
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 _____