Hydro-Sonic Family/Athlete Health Evaluation Questionnaire

Have you or anyone in your immediate household been exposed to a COVID positive individual?
Yes__________ No__________
Have you or anyone in your immediate household shown symptoms of COVID-19 in the past 14 days?
Yes__________ No__________
Symptoms include:

• Fever or Chills	• Cough
• Shortness of breath or difficulty breathing	• Fatigue
• Muscle or body aches	• Headache
• New loss of taste or smell	• Sore throat
• Congestion or runny nose	• Diarrhea

Have you or anyone in your immediate household traveled internationally in the last 14 days?
Yes__________ No__________
Have you or anyone in your immediate household traveled to a location in the United States where an increased incidence of COVID-19 has been reported in the last 14 days?
Yes__________ No__________
Have you or anyone in your immediate household been instructed by a healthcare provider to self-quarantine due to potential COVD-19 exposure?
Yes__________ No__________
Have you or anyone in your immediate household been tested for COVID-19 in the past 14 days?
Yes__________ No__________
If Yes, please provide test date & result:
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