

## POST COVID-19 ASSESSMENT CHECK

### Section 1: Athlete Background

Athlete Name: \_\_\_\_\_ Date: \_\_\_\_\_

Sport/Activity: \_\_\_\_\_ Level of Activity: \_\_\_\_\_

Date of Last COVID-19 PCR Test: \_\_\_\_\_

Date of Last COVID-19 Antigen Test (if available): \_\_\_\_\_

How long was the recovery time? \_\_\_\_\_

Was the athlete hospitalized during the time of illness? YES NO

Other general health concerns/comorbidities? YES NO

If yes, please list: \_\_\_\_\_

### Section 2: Symptom Evaluation

The athlete should note down any symptoms that are ONGOING NOW or HAD OCCURRED DURING THEIR ILLNESS. The athlete should read through the list of symptoms and check whether their symptom was present at the onset of their illness, whether it is currently ongoing, or whether they never experienced the symptom. If the symptom was present at onset or is current, the athlete should then rate their symptoms based on how they felt/currently feel.

Symptom* *Public Health Ontario as of Feb 5 2021	Time of Symptom	If symptom was present at onset or is current, please rate:					
		MILD		MODERATE		SEVERE	
Difficulty breathing	<input type="checkbox"/> Never (0) <input type="checkbox"/> At Onset <input type="checkbox"/> Current	1	2	3	4	5	6
Severe chest pain	<input type="checkbox"/> Never (0) <input type="checkbox"/> At Onset <input type="checkbox"/> Current	1	2	3	4	5	6
Feeling confused or unsure of where you are	<input type="checkbox"/> Never (0) <input type="checkbox"/> At Onset <input type="checkbox"/> Current	1	2	3	4	5	6
Losing consciousness	<input type="checkbox"/> Never (0) <input type="checkbox"/> At Onset <input type="checkbox"/> Current	1	2	3	4	5	6
Fever and/or chills	<input type="checkbox"/> Never (0) <input type="checkbox"/> At Onset <input type="checkbox"/> Current	1	2	3	4	5	6

GUELPH • ONTARIO • CANADA

Cough or barking cough (croup)	<input type="checkbox"/> Never (0) <input type="checkbox"/> At Onset <input type="checkbox"/> Current	1	2	3	4	5	6
Shortness of breath	<input type="checkbox"/> Never (0) <input type="checkbox"/> At Onset <input type="checkbox"/> Current	1	2	3	4	5	6
Sore throat	<input type="checkbox"/> Never (0) <input type="checkbox"/> At Onset <input type="checkbox"/> Current	1	2	3	4	5	6
Difficulty Swallowing	<input type="checkbox"/> Never (0) <input type="checkbox"/> At Onset <input type="checkbox"/> Current	1	2	3	4	5	6
Running or stuffy/congested nose	<input type="checkbox"/> Never (0) <input type="checkbox"/> At Onset <input type="checkbox"/> Current	1	2	3	4	5	6
Decrease or loss of taste or smell	<input type="checkbox"/> Never (0) <input type="checkbox"/> At Onset <input type="checkbox"/> Current	1	2	3	4	5	6
Conjunctivitis (pink eye)	<input type="checkbox"/> Never (0) <input type="checkbox"/> At Onset <input type="checkbox"/> Current	1	2	3	4	5	6
Headache	<input type="checkbox"/> Never (0) <input type="checkbox"/> At Onset <input type="checkbox"/> Current	1	2	3	4	5	6
Nausea/vomiting	<input type="checkbox"/> Never (0) <input type="checkbox"/> At Onset <input type="checkbox"/> Current	1	2	3	4	5	6
Diarrhea	<input type="checkbox"/> Never (0) <input type="checkbox"/> At Onset <input type="checkbox"/> Current	1	2	3	4	5	6
Stomach pain	<input type="checkbox"/> Never (0) <input type="checkbox"/> At Onset <input type="checkbox"/> Current	1	2	3	4	5	6
Muscle aches	<input type="checkbox"/> Never (0) <input type="checkbox"/> At Onset <input type="checkbox"/> Current	1	2	3	4	5	6
Extreme tiredness	<input type="checkbox"/> Never (0) <input type="checkbox"/> At Onset <input type="checkbox"/> Current	1	2	3	4	5	6
Falling down often (older adults)	<input type="checkbox"/> Never (0) <input type="checkbox"/> At Onset <input type="checkbox"/> Current	1	2	3	4	5	6
Total Number of Symptoms					of 19		
Symptom Severity Score					of 114		

**Additional Information:**

O2 Saturation	<input type="checkbox"/> At Assessment	%
Heart Rate	<input type="checkbox"/> At Assessment	bpm

**Section 3: Function Screen**

(From Elliott N, et al. BJSM. [2020 Oct 1;54\(19\):1174-5.](#))

Is the athlete:

Able to complete regular activities of daily living?	YES	NO
Able to walk ~500m on the flat without excessive fatigue or breathlessness?	YES	NO
At least 7 days symptom-free?	YES	NO

*If the athlete/covid client answers YES to all of the below, they may proceed with graduated return to play following medical clearance. Otherwise they should remain in the rehab phase where their chronic symptoms can be treated.*

**Please fill out this checklist and either:**

- **Print it at home and bring with you to your initial assessment**
- **Email a completed filled out copy to your EPA Clinic's admin team.**

**Clinic emails can be found on the locations page here**