Name: ____

Date of Birth: __________________________________

COVID-19 Health History

1. Have you been diagnosed with COVID-19?

   – Date of Diagnosis ________________________

   – Was the Diagnosis confirmed with a COVID-19 Test (circle one): **YES** **NO**

2. If you tested **positive** for COVID-19, are you experiencing any lingering symptoms? - please list below

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3. Do you have any other conditions that may **mimic** the symptoms of COVID-19?

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COVID-19 Vaccination History

Have you completed a COVID-19 vaccination series (circle one): **YES** **NO**

– Date of completion: ______________________

Signed: ____ Date: _____________

Parent/Guardian Name: ____

Parent/Guardian Signature (if under 18): ________________________________ Date: _____________