ATHLETIC
ARTS
ACADEMY

Phone: 973-518-2368
coach_iya@athleticartsacademynj.com

Student Medical History Survey

Student Name:_____

Parent / Guardian Name:_____

All of the above questions have been answered completely and truthfully to the best of our knowledge.

	YES	NO
Does participant have any condition that would preclude or limit participation in our programs? If yes, please explain:	☐	☐
Has participant every been informed that they have Asthma?	☐	☐
Is the Asthma controlled by medication? If yes, please explain:	☐	☐
Has participant every been informed that they might have epilepsy, or every experienced a seizure?	☐	☐
Has participant been treated or infectious mononucleosis, viral pneumonia, or another infectious disease during the past twelve months? If yes, please explain:	☐	☐
Has participant ever been treated for or informed by a medical doctor that they have a heart problem, a heart murmur, or high blood pressure? If yes, please explain:	☐	☐
Has participant ever been told that they have a hernia?	☐	☐
Is the hernia repaired?	☐	☐
Has participant had any operations in the past two years? If so, please indicate when and what for.	☐	☐
Is the participant currently taking prescribed medications? If so, indicate name of drug and indicate why it is prescribed.	☐	☐
As participant ever been treated for Osgood-Shlatter (knee) Disease?	☐	☐
Has participant had a fracture during the past two years? If yes, indicate the site of the fracture and the date:	☐	☐
Has participant had any joint dislocation during the past two years? If yes, indicate which joint:	☐	☐
Does participant every experience pain in the back? If yes, indicate frequency by circle one answer: Seldom ☐ Occasionally ☐ Frequently ☐ W/Vigorous exercise or heavy lifting ☐		
Is participant allergic to penicillin or any other medications? If so, please list:	☐	☐
Does participant have any other allergies (i.e., foods, bug stings/bites, iodine, etc.)	☐	☐
Weight: _____ Height: _____ Last Physical: _____ Results: _____		
Have there been any disciplinary, emotional, learning disabilities or other concerns which we should be aware of? ADHD, Recent loss of a loved one or housing relocation, for example? If so, please explain:	☐	☐

_____ _____

Parent / Guardian Signature Date

COVID-19 SCREENING QUESTIONNAIRE

The safety of our students and staff are our overriding priority. As the coronavirus (COVID-19) pandemic continues, we are monitoring the situation closely and following the guidance from the Centers for Disease Control and Prevention and local health authorities. In order to prevent the spread of the coronavirus and reduce the potential risk of exposure to our workforce, we are asking everyone to complete and submit this questionnaire prior to registering for our programs and entering the Academy. Please do not enter the Academy until your responses have been reviewed and your registration has been approved.

Please respond to each of the following questions truthfully and to the best of your ability. Your participation is important to help us take precautionary measures to protect you and our gymnastics family members.

	Representations
1	Are you currently experiencing, or have you experienced in the past 14 days, any of the following symptoms? (***Please take your temperature before you answer this question.)*** ◯ Fever *(100.4° F/37.8° C or greater as measured by an oral thermometer)* ◯ Cough ◯ Shortness of breath or difficulty breathing ◯ Sore throat ◯ New loss of taste or smell ◯ Chills ◯ Head or muscle aches ◯ Nausea, diarrhea, vomiting
2	In the past 14 days, has the student been in close proximity to anyone who was experiencing any of the above symptoms or has experienced any of the above symptoms since your contact? ☐ ☐
3	In the past 14 days, has the student been in close proximity to anyone who has tested positive for COVID-19? ☐ ☐
4	Has the student been tested for COVID-19 and are waiting to receive test results? ☐ ☐
5	Has the student been tested positive for COVID-19, or presumptively positive for COVID-19 based on a health care provider's assessment or symptoms? ☐ ☐ *NOTE: If you or your child have tested positive for COVID-19 or have been presumptively positive for COVID-19 based on your health care provider's assessment or your symptoms, please contact us when: (1) there is no fever for at least 72 hours (3 full days), without the use of fever-reducing medications; (2) the other symptoms have improved;* ***and*** *at least 14 days have elapsed since your symptoms first appeared.*

6	In the past 14 days, has the student been on a commercial flight or traveled outside of the United States? ☐ ☐
7	In the past 14 days, has the student been in close proximity to anyone who has been on a commercial flight or traveled outside of the United States? ☐ ☐
8	Is there any reason why the student may be at higher risk of contracting COVID-19 or experiencing complications from COVID-19 by entering the facility? Compromised immune system, for example? If "yes", please provide a brief explanation. ☐ ☐ *Brief explanation or additional information*: _____ _____
	Please attached copy of current immunization record.
	Certification **I hereby certify that I am the parent/guardian of _____** **the responses provided above are true and accurate to the best of my knowledge.** Signature:_____ Date: _____ *Note: The information collected on this form will be used to determine only whether you may be infected with COVID-19. The information on this form will be maintained as confidential in accordance with CDC guidelines.* Access to Camp/Classes (circle one): Approved ☐ Denied ☐