Wisconsin Department of Safety and Professional Services
Mail To: P.O. Box 8935
Madison, WI 53708-8935
Phone: (608) 261-8503
FAX: (608) 223-6532

Office Location: 4822 Madison Yards Way
Madison, WI 53705
Email: dspscombativesports@wisconsin.gov
Website: http://dsps.wi.gov

UNARMED COMBAT SPORTS
COVID-19 QUESTIONNAIRE

Date of Event	_____ / _____ / ________
Name	
Mailing Address	
City, State, Zip Code	
Position	☐ Physician ☐ Contestant ☐ Second ☐ Ring Official

Health Condition: **Have you experienced any of the following symptoms in the last 14 days?**

Fever or Chills	No ☐	Yes ☐
Cough	No ☐	Yes ☐
Shortness of Breath or Difficulty Breathing	No ☐	Yes ☐
Fatigue	No ☐	Yes ☐
Muscle or Body Aches	No ☐	Yes ☐
Head Aches	No ☐	Yes ☐
New Loss of Taste or Smell	No ☐	Yes ☐
Sore Throat	No ☐	Yes ☐
Congestion or Runny Nose	No ☐	Yes ☐
Nausea or Vomiting	No ☐	Yes ☐
Diarrhea	No ☐	Yes ☐

Epidemiological History:

Have you had contact with any respiratory disease cases in the last 14 days?	No ☐	Yes ☐
Has any family member or close acquaintance been diagnosed with COVID-19 or is now under surveillance as a suspected case?	No ☐	Yes ☐
Has any family member or close acquaintance had contact with someone diagnosed with COVID-19, or that might be under surveillance as a suspected case? • You were within 6 feet of someone who has COVID-19 for a total of 15 minutes or more • You provided care at home to someone who is sick with COVID-19 • You had direct physical contact with the person (hugged or kissed them) • You shared eating or drinking utensils • They sneezed, coughed, or somehow got respiratory droplets on you	No ☐	Yes ☐
Have you been tested for the detection of COVID-19?	No ☐	Yes ☐
Date of Test	_____ / _____ / ________	
Results of Test	Positive ☐	Negative ☐

After reading and completing this COVID-19 questionnaire, I declare that to the best of my knowledge, all the information expressed herein is truthful.

Signature ______________________________ **Date** ☐☐ / ☐☐ / ☐☐☐☐
(Print and Sign Form) (month) (day) (year)