COVID-19 SCREENING FORM

(Circle all answers)

Name;	Date:
Phone Number (mobile/home):	email address:
Position:	

REPRESENTATIONS

1	Are you currently experiencing, or have you experienced in the past 14 days, any of the following symptoms? (Circle Yes or No) Yes No Fever (100.4° F/37.8° C or greater) Yes No Cough Yes No Shortness of breath or difficulty breathing Yes No Sore throat Yes No New loss of taste or smell Yes No Chills Yes No Head or muscle aches Yes No Nausea, diarrhea, vomiting
2	In past 14 days, have you been in close proximity to anyone who was experiencing any of the above symptoms or has experienced any of the above symptoms since contact? Yes No
3	In the past 14 days, have you been in close proximity to anyone who has tested positive for COVID-19? Yes No
4	Have you been tested for COVID--19 and are waiting to receive test results? Yes No

5	Have you tested positive for COVID•l9, or are you presumptively positive for COVID-19 based on your health care provider's assessment or your symptoms? Yes No
6	In the past 14 days, have you been on a commercial flight or traveled outside of the United States? Yes No
7	In the past 14 days, have you been in close proximity to anyone who has been on a commercial flight or traveled outside of the United States? Yes No
8	Is there any reason why you feel you are at higher risk of contracting COVID-19 or experiencing complications from COVID-19 by participating in this event? If **"YES"** please provide a brief explanation. Yes No Explanation: _____

I hereby certify that the responses provided in this form are true and accurate to the best of my knowledge

Signature: _____

Date: _____

EVENT LOCATION: _____

(City)

CURRENT TEMPERATURE: _____