COVID-19 Screening Questionnaire

Name: Date: (Please Print) _____

Location: _____

Phone #: _____

1. Have you had any of the following **new or worsening** symptoms or signs? *Symptoms should not be chronic or related to other known causes or conditions.*

Fever or chills	☐ Yes ☐ No
Difficulty breathing or shortness of breath	☐ Yes ☐ No
Cough	☐ Yes ☐ No
Sore throat, trouble swallowing	☐ Yes ☐ No
Runny nose/stuffy nose or nasal congestion	☐ Yes ☐ No
Decrease or loss of smell or taste	☐ Yes ☐ No
Nausea, vomiting, diarrhea, abdominal pain	☐ Yes ☐ No
Not feeling well, extreme tiredness, sore muscles	☐ Yes ☐ No

2. Have you travelled outside of your Country in the past 14 days? ☐ Yes ☐ No

3. Have you had close contact with a confirmed or probable case of Covid-19? ☐ Yes ☐ No

If you answer **NO to all questions from 1 through 3,** you have passed and can enter the meeting or event.

If you answer **YES to any questions from 1 through 3**, you have **not passed** and you **may not** enter the event or meeting (including any outdoor, or partially outdoor, places). You should go home to **self-isolate immediately** and **contact your health care provider**.

By signing this form, you affirm to the best of your knowledge, information and belief, that the answers you provide are truthful to the best of your knowledge.

Signature: _____

Print name _____