COVID Questionnaire

Please answer the following questions honestly

Have you had any of the following symptoms within 14 days of the beginning of the event?

- ○ Cough
- ○ Sore Throat
- ○ Fever
- ○ Shortness of Breath
- ○ Shaking With Chills
- ○ Muscle Aches
- ○ Headache
- ○ Loss of Taste/Smell
- ○ Nausea, Vomiting, Diarrhea

Have you traveled outside of your community in the past 14 days

- ○ Yes
- ○ No

Have you been in close contact with someone diagnosed with COVID-19 in the past 14 days?

- ○ Yes
- ○ No

Have you been tested for COVID-19

- ○ Yes
- ○ No

If yes, when? ________________

Results______________________