COVID-19 SCREENING

Temperature:_____

Have you displayed any of the following symptoms in the past 14 days? Check YES or NO

- Fever [ ] YES [ ] NO
- Chills [ ] YES [ ] NO
- Repeated Shaking With Chills [ ] YES [ ] NO
- Cough [ ] YES [ ] NO
- Shortness of Breath or Difficulty Breathing [ ] YES [ ] NO
- Muscle Pain [ ] YES [ ] NO
- Headache [ ] YES [ ] NO
- Sore Throat [ ] YES [ ] NO
- Loss of Smell or Taste [ ] YES [ ] NO

Have you been in direct, close contact with any person that has tested positive for COVID-19 within the last 14 days? [ ] YES [ ] NO

_____ _____ _____

Print/Guest Name Signature Date