COVID-19 WELLNESS SCREENER

DATE____________________

NAME____

Other than your normal allergies or a cold, check any of the following symptoms you are experiencing:

___Fever of 100.4 or great ___Headache
___Muscle Pain and Body Aches ___Unusual Fatigue
___Sore Throat ___Runny Nose
___Nausea, Vomiting, Diarrhea ___Congestion

If you have two or more symptoms you will need self-quarantine and test for COVID-19. You will need to show a negative test before returning.

___I have been diagnosed with COVID-19
If yes Date____________________
(You will not be allowed to participate until you have tested negative.)
___I have been within 6 feet proximity for over 15 minutes of a person diagnosed with COVID-19 in the last 2 weeks (If yes you will need to show a negative test result to participate.

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