# COVID – 19 QUESTIONNAIRE

(a copy of this document is needed for every participant and must be kept on file)

| | |
|---|---|
| **Participant**: ______________________ | **Event Name: ______________________** |
| **Contact Phone: ___________________** | **Date: ____________________________** |
| **Contact E-mail**: ___________________ | **Health/Safety Officer: _____________** |

**In the last 48 hours, have you experienced any of the following symptoms? (Please check "yes" or "no.") If "yes" is answered to any question the respondent may not attend the event.**

| Symptom | Yes | No |
|---|---|---|
| **Body temperature 100F or greater** | | |
| **Record Temperature:** | | |
| **Chills** | | |
| **Cough** | | |
| **Shortness of breath or difficulty breathing** | | |
| **Fatigue** | | |
| **Muscle or body aches** | | |
| **Headache** | | |
| **New loss of taste or smell** | | |
| **Sore throat** | | |
| **Congestion or runny nose** | | |
| **Nausea or vomiting** | | |
| **Diarrhea** | | |
| **Within the last 10 days have you had a COVID test and not received results?** | | |
| **Within the last 10 days have you been diagnosed with COVID-19, or tested positive for COVID-19?** | | |
| **Do you live in the same household with, or have had close contact with someone who within the past 14 days has (1) been in isolation for COVID-19; or (2) tested positive for COVID-19?** | | |
| **Comments:** | | |