Covid-19 Screening Questionnaire

To be completed by one member of each party. Please include each name in your family:

- 1. Name _____
- 2. Name _____
- 3. Name _____
- 4. Name _____

Phone _____ Email _____

Are you experiencing or have you experienced in the past 14 days, any of the following symptoms?

Fever, cough, shortness of breath, sore throat, new loss of taste or smell, chills, head or muscle ached, nausea, diarrhea, vomiting YES _____ NO _____ If yes, we ask you to exit the building or explain below.

I hereby certify that the responses provided above are true and accurate to the best of my knowledge.

Signature: _____