PILATES OF HAWAII COVID SCREENING

Name_______________________________________ Date______________________

In the last 14 days, have you traveled outside your normal daily routine, or traveled out of state?

YES O NO O

Do you have new onset or worsening of any of the following symptoms: fever, cough, shortness of breath, runny nose, sore throat, chills, body aches, fatigue, headache, loss of taste or smell, eye drainage, congestion?

YES O NO O

If yes to any of the above, please list symptoms:

Have you been exposed to anyone being tested for Covid-19 or who has symptoms compatible with Covid-19?

YES O NO O

Are any members of your household or close contacts in quarantine for exposure to Covid-19?

YES O NO O

Temperature today_____________________

If you have answered "Yes" to any of these questions, we request that you please stay home and do not attend class.