COVID-19 FORM

In the past 48 hours, have you experienced any of the following symptoms?

Fever, fatigue, cough, lost of taste and smell, muscle aches, sore throat, diarrhea, or headache?

- ○ YES
- ○ NO

Have you recently been in close contact with anyone who has exhibited any symptoms of COVID-19?

- ○ YES
- ○ NO

Have you recently been in contact with anyone who has tested positive for COVID-19?

- ○ YES
- ○ NO

I attest that the foregoing information is true and correct.

Name:

Signature

Date: