
# COVID-19 Screening Questionnaire

**Do you have a fever, or have you had a fever within the past 14 days? Yes_____No_____**

**Do you exhibit, or have you exhibited within the past 14 days, any symptoms associated with COVID-19, such as: cough, shortness of breath, difficulty breathing, chills/shaking, muscle pain, headache, sore throat, loss of taste or smell, gastro-intestinal upset, diarrhea? Yes_____No_____**

**Do you have any other flu-like symptoms? Yes_____No_____**

**Are you in contact with anyone who has been confirmed to be COVID-19 positive? Yes_____No_____**

**Have you been tested for COVID-19? Yes_____No_____**
**If yes, what was the result?_____**

*****I understand that I am responsible to immediately notify Ace Fencing Academy should any of my responses to this questionnaire change.*****

*****I have read and agree to abide by Ace Fencing Academy's COVID-19 Policies & Procedures.*****

**Name (print): _____**

**Signed (parent/guardian of minor): _____**

**Date: _____**

June 11, 2020