CONTACT INFORMATION AND HEALTH SURVEY FORM

(A separate form must be completed for each attendee)

Name:_____ (PLEASE PRINT ALL INFORMATION)

Address:_____

_____

Telephone number: _____

Email address: _____

HEALTH SURVEY

Have you had ANY symptoms of COVID-19 in the last 14 Days? Symptoms include: FEVER, CHLLS, LOSS OF TASTE OR SMELL, COUGH, SHORTNESS OF BREATH, TROUBLE BREATHING, MUSCLE PAIN, HEADACHES, SORE THROAT.

_____ Yes _____ No

Have you had ANY close contact with persons suspected of OR having COVID-19 in the last 14 days?

_____ Yes _____ No

IF YOU ANSWER YES TO ANY OF THE QUESTIONS ON THE HEALTH SURVEY WE CANNOT ALLOW YOU TO REMAIN ON THE PREMISES