Attendee COVID-19 Screening Form

Attendee Name: ________________________________
Date: ____________

Question		
Do you have a fever or above-normal temperature (>100F)?	YES☐	NO☐
Have you taken fever reducers in the past 72 hours?	YES☐	NO☐
Have you been experiencing shortness of breath or having trouble breathing?	YES☐	NO☐
In the past 72 hours, have you had a dry cough?	YES☐	NO☐
In the past 72 hours, have you had a runny nose?	YES☐	NO☐
In the past 72 hours, have you had a sore throat?	YES☐	NO☐
Have you recently lost or had a reduction in your sense of smell or taste?	YES☐	NO☐
In the past 72 hours, have you had any other flu-like symptoms (stomach upset, headache, muscle pain or fatigue)?	YES☐	NO☐
In the past 72 hours, have you had chills or repeated shaking with chills?	YES☐	NO☐
Have you been tested for COVID-19? If YES, date tested __________ & what is the result? _____ Positive ____Negative _____Awaiting result	YES☐	NO☐
In the last 14 days, have you been in contact with someone who has a confirmed case COVID-19, under investigation for COVID-19 or a respiratory illness?	YES☐	NO☐
In the last 14 days, have you traveled to any foreign country? If YES, where?______________________	YES☐	NO☐
In the last 14 days, have you traveled to a state outside of MA? If YES, where?______________________	YES☐	NO☐
Do you give permission for your daughter to use hand sanitizer?	YES☐	NO☐

Parent Signature_________________________________ **Date :** ____________