COVID SYMPTOM SCREEN

NAME: _____ **DATE:_____**

In the past 7 days, have you had any of these common symptoms of COVID-19

- Cough
- Stuffy or runny nose
- Sore throat
- Shortness of breath
- Temperature above 100 degrees
- New or worsening headache
- Gastrointestinal symptoms (nausea, vomiting, or diarrhea)
- Complete loss of taste or smell

In the past 7 days, have you had close contact with anyone with COVID-19 (< 6ft of distance for >10 min without a mask)

- Yes
- No

In the past 14 days have you failed to follow the Governor's recommendations for social distancing and public health procedures?

- Yes
- No

Temperature:_____°F

If you have a temperature >100°F or answer yes to any of the above questions you will not be allowed to enter the gym.

STAFF INITIALS: