COVID -19 Screening Questionnaire

First Name: ______________________________ Last Name: ________________________________

Street: ____

City: ____ State: _____ Zip: ___________

Phone: ________________________________ Email: _____________________________________

Please **check** all that apply:

- ☐ You had a close contact with confirmed or suspected COVID-19 cases within the past 14 days
- ☐ You traveled out of the US and/or any state that requires quarantine in the past 14 days
- ☐ You had a positive COVID-19 test within the past 14 days
- ☐ You have pending COVID-19 test results
- ☐ You have a fever above 100 degrees Fahrenheit
  - ☐ **NONE OF THE ABOVE**

- ☐ Within the past 14 days you had the following COVID-19 symptoms (Check all that apply)
- ☐ New Unexplained Cough
- ☐ New Unexplained Shortness of Breath
- ☐ New Unexplained Fever
- ☐ New Unexplained Chills
- ☐ New Unexplained Muscle Pain
- ☐ New Unexplained Sore Throat
  - ☐ **NO SYMPTOMS**

Please remember to stay **SAFE**. Please wear a facial mask, maintain social distance and wash your hands for 20 seconds before and after your workout program.

Print Name: ____

Signature: ____ Date: ________________