Covid19 Wellness Questionnaire

Name(s) of those attending: __________________________________________

Phone #: ___________________________ Email: __________________________

Physical Address: __________________________________________________

Have you or anyone in your family unit experienced any of the following symptoms:

- Cough  □ yes □ no
- Fever of 100.4F or higher □ yes □ no
- Chills □ yes □ no
- Muscle Pain/Headache □ yes □ no
- Shortness of Breath □ yes □ no
- Sore Throat □ yes □ no
- Loss of taste or smell □ yes □ no

Additional Questions:

Have you or anyone in your family unit had exposure to someone with, or under investigation for, COVID19?
□ yes □ no

Signature: _______________________________________________________

Date & Time: _____________________________________________________

Temperature of those attending:
Name/Temperature ___________________________ Name/Temperature __________
Name/Temperature ___________________________ Name/Temperature __________
Name/Temperature ___________________________ Name/Temperature __________