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 returned from domestic or international travel in the last 14 days?

☐ yes ☐ no

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 _____