COVID-19 Questionnaire

Please answer the following questions:

1. **Yes / No** - Have you (or your child under 18) been in close contact with a confirmed case of COVID-19 in the past 14 days?

2. **Yes / No** - Are you (or your child under 18) experiencing a cough, shortness of breath, or sore throat?

3. **Yes / No** - Have you (or your child under 18) had a fever in the last 48 hours?

4. **Yes / No** - Have you (or your child under 18) had a recent loss of taste or smell?

5. **Yes / No** - Have you (or your child under 18) had vomiting or diarrhea in the last 24 hours?

_____ _____

Participant Name (Print Clearly) Date

_____ _____

Parent/Guardian Signature Parent/Guardian Name (Print Clearly)