

Flu & COVID-19 Screening Questionnaire

Print Name: _____

Phone# _____

Address _____

E-mail for upcoming events _____

1. Complete temperature screening with infra-red thermometer at front entrance.
2. Are you currently experiencing any of the following symptoms: cough, fever, shortness of breath, or sore throat? Y/N: _____
3. Have you traveled internationally in the last 14 days? Y/N: _____
4. Have you visited or do you reside in a community with confirmed community spread of COVID-19? Y/N: _____
5. Have you been exposed to anyone who has tested positive or is under investigation for COVID-19? Y/N: _____
6. By signing this document you agree to wear a mask if you are unvaccinated at all times except when eating or drinking at designated locations. You also agree to social distance except when with your family or party.

Signature: _____

Date: _____

*** All INFORMATION ON THIS FORM WILL NOT BE SOLD OR GIVEN TO A THIRD PARTY AND WILL BE DESTROYED AFTER 30 DAYS IN ACCORDANCE WITH CDC GUIDELINES.**