NAME: _____

DATE: _____ PHONE # _____

CLUB: _____

COVID-19 HEALTH QUESTIONNAIRE

Please answer the following 14 questions:

In the past fourteen (14) days, have you experienced any of the following symptoms:

1) Fever (100.4°F or higher) or Chills:

☐ Yes ☐ No

2) Fatigue:

☐ Yes ☐ No

3) Cough:

☐ Yes ☐ No

4) New Loss of Taste or Smell:

☐ Yes ☐ No

5) Muscle or Body Aches:

☐ Yes ☐ No

6) Congestion or Runny Nose:

☐ Yes ☐ No

7) Sore Throat:

☐ Yes ☐ No

8) Diarrhea:

☐ Yes ☐ No

9) Shortness of Breath or Difficulty Breathing:

☐ Yes ☐ No

10) Headaches:

☐ Yes ☐ No

11) Nausea or Vomiting:

☐ Yes ☐ No

12) Have you been in contact with anyone who has exhibited any of the above symptoms within the last fourteen (14) days?

☐ Yes ☐ No

13) Have you been in contact with anyone who has been diagnosed with COVID-19 within the last fourteen (14) days?

☐ Yes ☐ No

14) Have you traveled to the Commonwealth of Pennsylvania from another state or international location within the last fourteen (14) days?

☐ Yes ☐ No If Yes - from where: _____