COVID-19 Pre-Session / Class Symptom and Exposure Screening Questionnaire

Name_____ Date_____

It is important to stay home if you are ill. Please read and answer these questions prior to your session/class.

Are you fully vaccinated? Yes No Prefer not to say

Are you experiencing any ONE of the following symptoms? Please circle.

Dry Cough Fever over 99.9 Shortness of breath / Difficulty breathing

Are you experiencing any TWO of the following symptoms? Please circle.

Chills Repeated shaking Headache Sore throat Diarrhea

Muscle/body aches New loss of taste and/or smell

Nausea/vomiting Fatigue Congestion or runny nose

Have you been ordered to self-quarantine by a health care provider or public health official due to COVID-19 illness or exposure?

Yes No

Have you had contact with anyone who has been diagnosed with COVID-19 or was experiencing symptoms of COVID-19 in the last 14 days?

Yes No

If you have answered Yes to any of the symptom questions, please reschedule and consider being tested.

Signature