# ELECTING CONVENTION COVID-19 SCREENING FORM

Please read each question carefully and circle the answer that applies. No health information or questionnaire answers will be shared with anyone other than the organizers of this event.

Have you experienced any of the following symptoms of COVID-19 within the last 48 hours?

| | | |
|---|---|---|
| • Fever or chills | YES | NO |
| • Cough | YES | NO |
| • Shortness of breath or difficulty breathing | YES | NO |
| • Fatigue | YES | NO |
| • Muscle or body aches | YES | NO |
| • Headache | YES | NO |
| • New loss of taste or smell | YES | NO |
| • Sore throat | YES | NO |
| • Congestion or runny nose | YES | NO |
| • Nausea or vomiting | YES | NO |
| • Diarrhea | YES | NO |
| Have you tested positive for COVID-19 in the past 10 days? | YES | NO |
| Are you currently awaiting results from a COVID-19 test? | YES | NO |
| Have you been diagnosed with COVID-19 by a licensed healthcare provider in the past 10 days? | YES | NO |
| Have you been told that you are suspected to have COVID-19 by a licensed healthcare provider in the past 10 days? | YES | NO |
| Have you been in close physical contact in the last 14 days with anyone who is known to have laboratory-confirmed COVID-19 or anyone who has any symptoms consistent with COVID-19? | YES | NO |

I CERTIFY THAT MY RESPONSES ARE TRUE AND CORRECT

X _____ DATE: 9/25/21

Please Print name: _____

***For Official Use only. Documentation Received:***

***Vaccination Card_____ Negative PCR Test _____ Rapid Test_____***