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 YES NO

healthcare provider in the past 10 days?

Have you been told that you are suspected to have COVID-19 YES NO

by a licensed healthcare provider in the past 10 days?

Have you been in close physical contact in the last 14 days with YES NO

anyone who is known to have laboratory-confirmed COVID-19

or anyone who has any symptoms consistent with COVID-19?

I CERTIFY THAT MY RESPONSES ARE TRUE AND CORRECT

X \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ DATE: 11/6/21

Please Print name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_