COVID-19 RELEASE FORM

QUESTIONS	YES	NO
Do you have any of these symptoms that are not caused by another known condition?	☐	☐
Within the past 14 days, have you had *contact with anyone that you know had COVID-19 or COVID like symptoms?	☐	☐
Have you traveled out of state or internationally in the last 14 days?	☐	☐
Have you had a positive COVID-19 test in the past 14 days?	☐	☐

- **Fever or Chills**
- **Cough**
- **Shortness of breath or difficulty breathing**
- **Fatigue**
- **Muscle or Body Aches**
- **Headache**
- **Recent loss of taste or smell**
- **Sore Throat**
- **Congestion**
- **Nausea or Vomiting**
- **Diarrhea**

FULL NAME _____ **DATE** _____

SIGNATURE _____