Date

Month Day Year

COVID-19 Health Screening

This pre-work Symptom Survey must be completed to training today. It is critically important that everyone training is healthy and symptom free. Please complete this brief survery.

Name *

First Name Last Name

Phone Number *

Area Code Phone Number

Heading

Are you currently experiencing any of these symptoms or have you experienced any of these symptoms in the last 24 hours? **If you answer yes to any of these questions, please speak with your Trainer.

Nausea *

- ○ Yes
- ○ No

Vomiting/Diarrhea *

- ○ Yes
- ○ No

Fever (100F or higher) *

- ○ Yes
- ○ No

Cough (not related to allergies) *

- ○ Yes
- ○ No

Abdominal Cramps *

- ○ Yes
- ○ No

Shortness of Breath *

- ○ Yes
- ○ No

Have you recently been tested for COVID-19 and are awaiting results? *

- ☐ Yes
- ☐ No

Have you been in close contact with someone with a confirmed diagnosis of COVID-19 or is being tested for COVID-19? *

- ○ Yes
- ○ No