COVID-19 SCREENING QUESTIONNAIRE

PLEASE ANSWER THE FOLLOWING QUESTIONS:

Are you experiencing or have you in the past 14 days experienced any symptoms associated with COVID-19 such as cough, shortness of breath or difficulty breathing, body aches, chills, headache, sore throat, congestion or runny nose, nausea or vomiting, or diarrhea? YES NO

Have you had a fever of 100.4F or higher in the past 14 days? YES NO

Do you have a household member or other close contact who is experiencing (or has experienced in the past 14 days) any fever of 100.4F or higher, or any other of the symptoms of COVID-19 as listed above?
YES NO

Have you been diagnosed with or exposed to anyone with a diagnosis of COVID-19 in the past 14 days?
YES NO

Are you currently isolating or quarantining because you may have been exposed to a person with COVID-19? YES
NO

By signing this form, I hereby affirm and testify that the information I have provided for myself (or minor child,) is true and correct to the best of my knowledge. I agree to follow all rules and regulations as set forth by the Tobacco Road Marathon Committee.

Bib #:_____

Print Name: _____

Signature_____
Date_____