**Varsity Shop Training Center COVID-19 Screening Questionnaire**

Name:

Date:

Email Address:

Phone Number:

1. Have you been diagnosed with COVID-19 within the past 14 days?
* YES
* NO
1. Have you had close contact with or cared for someone who has tested positive for COVID-19 within the past 14 days?
* YES
* NO
1. Have you been in close contact with a suspected case of COVID-19 within the past 14 days?
* YES
* NO
1. Have you experienced within the last 14 days, or are you currently experiencing, any of the following symptoms:

Fever or chills 🞏 YES 🞏 NO

Dry cough 🞏 YES 🞏 NO

Difficulty breathing or shortness of breath 🞏 YES 🞏 NO

Fatigue 🞏 YES 🞏 NO

Muscle or body aches 🞏 YES 🞏 NO

Sore throat 🞏 YES 🞏 NO

Headache 🞏 YES 🞏 NO

Congestion or runny nose 🞏 YES 🞏 NO

Nausea or vomiting 🞏 YES 🞏 NO

Diarrhea 🞏 YES 🞏 NO

New loss of taste or smell 🞏 YES 🞏 NO

**Signature:**