COVID-19 Checklist

Please print neatly

First and Last Name: _____

Phone Number: _____

Email Address: _____

Event Name: _____

Date: _____

Time: _____

Temperature: _____

Please answer each question.

○ Yes ○ No	Have you traveled outside of the country in the last 14 days?
○ Yes ○ No	Are you experiencing any symptoms of COVID-19 now? ***See the back side***.
○ Yes ○ No	Do you have a cough?
○ Yes ○ No	Do you have shaking with chills?
○ Yes ○ No	Have you experienced recent loss of taste or smell?
○ Yes ○ No	Do you have a heart disorder, lung disorder, kidney disorder, any auto-immune disorder, or diabetes?
○ Yes ○ No	Have you been tested for COVID-19 within the last 10 days?
○ Yes ○ No	If yes, are you waiting for results?
○ Yes ○ No	Have you come in contact with any with confirmed COVID-19 symptoms within the last 14 days?
○ Yes ○ No	Have you had at least one shot of the COVID-19 vaccine?

If you have checked **yes** to any of the above questions, for your safety and safety of others, we kindly ask that you leave the event as not to affect other individuals at the event.

Your signature also agrees to keep your mask on and over your nose and mouth.

Signature: _____

COVID-19 Symptoms

Compared To Other Common Conditions

SYMPTOM	COVID-19	COMMON COLD	FLU	ALLERGIES
Fever	Common	Rare	Common	Sometimes
Dry cough	Common	Mild	Common	Sometimes
Shortness of breath	Common	No	No	Common
Headaches	Sometimes	Rare	Common	Sometimes
Aches and pains	Sometimes	Common	Common	No
Sore throat	Sometimes	Common	Common	No
Fatigue	Sometimes	Sometimes	Common	Sometimes
Diarrhea	Rare	No	Sometimes*	No
Runny nose	Rare	Common	Sometimes	Common
Sneezing	No	Common	No	Common

*Sometimes for children

SOURCES: CDC, WHO, American College of Allergy, Asthma and Immunology

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