COVID-19 Screening Form

To protect the health and safety of our participants we are requesting that you complete the following questionnaire.

1. Do you have any flu-like symptoms, i.e. a fever, sore throat, headache, runny nose, etc.?

   Yes No

2. Have you been in contact with, or have cared for, someone who is suspected or confirmed as *having COVID-19 in the last 14 days?*

   Yes No

3. Have you or any of your close contacts traveled outside of NH or to any of the high-risk areas (Massachusetts, New York, New Jersey, etc.) in the past 14 days, other than home or work?

   Yes No

4. Have you attended any large gatherings of 10 people or more in the past 14 days?

   Yes No

Yes to any = positive screen

If the screen is positive, contact your personal physician by phone. Do not go unannounced to the doctor's office.

****If the screen is positive, you will not be able to participate in class at this time. Thank you for your understanding.****

By signing, I am stating that I have answered the above questions honestly and accurately to the best of my knowledge and ability.

Client Signature _____ Date _____

Printed Name _____ Phone Number _____