COVID-19 Health Screening Questionnaire for Event Attendees

Full Name

Email Address

Phone Number

Event Date

1. Are you experiencing any of the following symptoms?

- Yes
- No

2. Have you tested positive for COVID-19 in the past 14 days?

- Yes
- No

3. Have you had close contact with someone confirmed or suspected of having COVID-19 in the past 14 days?

- Yes
- No

4. Have you traveled internationally in the past 14 days?

- Yes
- No

Additional Comments