COVID-19 Health Screening Form for Film Sets

Personal Information

Full Name

Role/Position

Date

Symptom Check

- [ ] Fever or chills
- [ ] Cough
- [ ] Shortness of breath or difficulty breathing
- [ ] Sore throat
- [ ] Muscle or body aches
- [ ] Loss of taste or smell
- [ ] Headache
- [ ] Nausea or vomiting
- [ ] Diarrhea

Contact & Exposure

Have you been in close contact with anyone who tested positive for COVID-19 in the past 14 days?

- ○ Yes
- ○ No

Have you tested positive for COVID-19 in the past 10 days?

- ○ Yes
- ○ No

Temperature

Temperature (°F)

Additional Comments