DAYTONA MEDICAL SCREENING QUESTIONNAIRE

NAME:_____

DATE:_____

Please complete this form just prior to your arrival. You will need 1 form filled out for each person receiving a wrist band.

In order to address participant safety and mitigate (as much as possible) potential exposure to COVID-19, DIS & WKA, requires daily screening for COVID-19 symptoms.

1. Have you had **NEW** or worsening cough, sore throat, shortness of breath, nausea, vomiting, diarrhea, muscle aches (not associated with strenuous physical activity) in the past 14 days?
   a. ☐ YES
   b. ☐ NO

2. Have you had a fever of 100° F or higher in the past 72 hours?
   a. ☐ YES
   b. ☐ NO

3. Have you felt feverish or had chills in the past 72 hours?
   a. ☐ YES
   b. ☐ NO

4. Are you experiencing new loss of taste or smell?
   a. ☐ YES
   b. ☐ NO

5. Have you recently been in close contact (less than 6 feet) with anyone experiencing symptoms as mentioned above or who has tested positive for COVID-19?
   a. ☐ YES
   b. ☐ NO
   c. ☐ I am a healthcare provider- I have been in contact with COVID-19 patients but was wearing appropriate PPE

_____

Signature

☐ Check here if you are a parent signing for a minor under the age of 18.