Have you received the COVID vaccine? Yes ☐ No ☐

If yes: When? Which arm was injected?

Have you tested positive for COVID-19 in the past 2 weeks?

Yes ☐ No ☐

In the past 2 weeks, have you had new or worsening onset of any of the following symptoms: fever, cough, shortness of breath, runny nose, sore throat, chills, headache, loss of taste /smell, eye drainage, or congestion?

Yes ☐ No ☐

Have you been asked to quarantine or been exposed to a person who has a confirmed positive COVID-19 test result within the last 2 weeks?

Yes ☐ No ☐

If YES: Please explain:

Signed: _____ Date: _____