

# **COVID-19 Screening Form**

Name: \_\_\_\_\_

Today's Date: \_\_\_\_\_

## **Screening for COVID-19**

We are screening for symptoms of COVID-19 to help us protect all guests.

**Please answer the questions below based on the last 10 days:**

1. **Have you** tested positive for COVID-19? Yes No
2. **Has anyone you've come in contact with** tested positive for COVID-19? Yes No

Have you had any of the following symptoms in the last 14 days? Check all that apply:

- I do not have any of the below symptoms
- Fever
- Cough
- Shortness of Breath
- Sore Throat
- Fatigue
- Other \_\_\_\_\_

By signing below, you are agreeing to not hold the Tampa Bay Beaches Chamber or the venue host liable if you contract COVID-19.

Signature: \_\_\_\_\_