# COVID Safety Form

Name: _____ Date: _____

**Please select if you have experienced the following in the past 14 days:**

- ❑ Dry cough
- ❑ Shortness of breath
- ❑ Fever
- ❑ Flu-like symptoms
- ❑ Loss of taste or smell
- ❑ Waiting for the results of a COVID test taken in the past 48 hours

**Please select if you have experienced the following in the past 30 days:**

- ❑ Domestic travel
    - ❑ If selected yes, where? _____
- ❑ International travel
    - ❑ If selected yes, where? _____
- ❑ Been in contact with somebody with COVID-19
- ❑ Tested positive for COVID-19

**Other:**

- ❑ _____
- ❑ _____

Thank you for your consideration!