Print Name **Bib #**

In the past 24 hours, I have experienced (indicate Y/N to these 7 items. after you have taken your temp):

Feeling feverish and My temp is 100.4 or higher: N

Cough (excluding chronic cough due to non-COVID-19 condition): N

Shortness of breath: N

Sore throat: N

Diarrhea (excluding diarrhea due to known medical reason other than COVID-19): N

In the last 14 days, have you traveled out of the country? N

In the last 14 days, have you been in contact with someone diagnosed with COVID-19? N

Signature Date