**GSEP COVID-19 Screening Form**

**Have you experienced any of the following symptoms in the past 48 hours:**

|  |  |  |
| --- | --- | --- |
| Fever or chills | Yes | No |
| Cough | Yes | No |
| Shortness of breath or difficulty breathing | Yes | No |
| Fatigue | Yes | No |
| Muscle or body aches | Yes | No |
| Headache | Yes | No |
| New loss of taste or smell | Yes | No |
| Sore throat | Yes | No |
| Congestion or runny nose | Yes | No |
| Nausea or vomiting | Yes | No |
| Diarrhea | Yes | No |
| Fever or chills | Yes | No |

**Within the past 14 days, have you been in close physical contact (6 feet or closer for a cumulative total of 15 minutes) with:**

|  |  |  |
| --- | --- | --- |
| Anyone who is known to have laboratory-confirmed COVID-19? | Yes | No |
| Anyone who has any symptoms consistent with COVID-19? | Yes | No |

**Are you or is anyone else in your household currently:**

|  |  |  |
| --- | --- | --- |
| Isolating or quarantining because of exposure to a person with COVID-19or worry that you/they may be sick with COVID-19? | Yes | No |
| Waiting on the results of a COVID-19 test? | Yes | No |

|  |  |  |
| --- | --- | --- |
| **Have you followed current Pennsylvania state travel guidelines/restrictions?** | Yes | No |

**For Adult Participant**

Adult Participant’s Printed Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Adults Participant’s Contact Number: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**For a Minor Participant**

Minor’s Printed Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Minor’s Parent/Legal Guardian Printed Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Parent/Legal Guardian Contact Number: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_