**Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date:\_\_\_\_\_\_\_\_\_\_ Staff Initial\_\_\_\_\_\_**

**COVID-19 Symptoms**

* Fever or chills
* Cough
* Shortness of breath or difficulty breathing
* Fatigue
* Muscle or body aches
* Headache
* New loss of taste or smell
* Sore throat
* Congestion or runny nose
* Nausea or vomiting
* Diarrhea

Wellness checks for staff and patrons before arriving to class and mid-day if applicable:

Y or N: Have you felt feverish?

Y or N: Do you have a cough?

Y or N: Do you have a sore throat?

Y or N: Have you been experiencing difficulty breathing or a shortness of breath?

Y or N: Do you have muscle aches?

Y or N: Have you had a new or unusual headache (e.g., not related to caffeine, diet, or hunger, not related to history of migraines, clusters, or tension, not typical to the individual)?

Y or N: Have you noticed a new loss of taste or loss of smell?

Y or N: Have you been experiencing chills or rigors (rigors: a sudden feeling of cold with shivering accompanied by a rise in temperature)?

Y or N: Do you have any gastrointestinal concerns (e.g., abdominal, pain, vomiting, diarrhea)?

Y or N: Is anyone in your household displaying any symptoms of COVID-19?

Y or N: To the best of your knowledge, have you or anyone in your household come into close contact with anyone who has tested positive for COVID-19 (close contacts include household contacts, intimate contacts, or contacts within 6-ft for 15 minutes or longer)