UUFoM COVID-19 Screening Form

Have you had any of the following symptoms in the last 14 days: ☐ Yes ☐ No

☐ Sore throat	☐ Cough
☐ Fever	☐ New loss of smell or taste
☐ Diarrhea	☐ Nausea or Vomiting
☐ Shortness of Breath	☐ Muscle or body aches
☐ Congestion	☐ Runny nose
☐ Fatigue	☐ Headache

Have you tested positive for COVID 19 in the last 14 days:

☐ Yes ☐ No

Have you been in close contact with anyone diagnosed with COVID 19 in the last 14 days?

☐ Yes ☐ No

If I develop any symptoms of COVID 19 in the next 14 days, I will contact the Safety Officer for today's event.

Disclaimer: I agree to grant to UUFoM permission to record on photography film and/or video, pictures of my participation in this event. I further agree that any or all of the material photographed may be used, in any form, as part of any future publications, brochure, or other printed materials used to promote UUFoM.

Name(Print): ____

Signature: ____

Email: ____