Name:________________________________ Phone #: ______________________

Do you have any symptoms related to COVID-19? (Chills, cough, shortness of breath, fatigue, muscle or body aches, headache, new loss of smell or taste, sore throat, congestion, nausea, or diarrhea)
Yes or No

Have you had direct contact (within 6 feet for 15 minutes) with a documented case of COVID-19 in the last 14 days? **Yes or No**

Date: ___________ Temperature: ____ (Will be taken as you enter the gate)

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