COVID-19 QUESTIONNAIRE

Name: _____ Date:_____

Questions – Please circle Yes or No

1. Have you had a fever or do you currently feel feverish?	Yes	No
2. Do you have a cough?	Yes	No
3. Are you having shortness of breath or trouble breathing?	Yes	No
4. Do you have chills or repeated shaking with chills?	Yes	No
5. Do you have any muscle pains?	Yes	No
6. Do you have any recent onset of headache or sore throat?	Yes	No
7. Do you have any FLU like symptoms?	Yes	No
8. Do you have and recent loss of taste or smell?	Yes	No
9. Have you experienced any recent GI upset or diarrhea?	Yes	No
10. Have you had contact with anyone testing positive for COVID-19 in the past 14 days?	Yes	No
11. Have you traveled to any regions impacted by COVID-19 in the past 14 days?	Yes	No
12. Have you been tested for COVID-19?	Yes	No
If yes, when?_____		
13. Have you been diagnosed with COVID-19?	Yes	No
If yes, when? _____		
14. Are you over the age of 65?	Yes	No

All Participants must fill out this questionnaire present it on day of race. No exceptions this is required by health department. Please print and bring with on race day.

Thank You!

Rockford Road Runners

Race Official:	A --- D