

Client, Crew, and Talent Symptoms Screening Form

Print Name

Phone Number (optional)

Email Address (optional)

1. Did any of the following symptoms first appear within the last 10 days?

- | | | |
|---|----|-----|
| a. Fever (at or over 100.4 degrees F or 38 degrees C) | No | Yes |
| b. Chills | No | Yes |
| c. Cough | No | Yes |
| d. Shortness of breath | No | Yes |
| e. Difficulty breathing | No | Yes |

2. Have you been in contact with a person known to be infected with the Novel Coronavirus (COVID-19) within the last 14 days?

No Yes

Signature

Date