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**DAILY WELLNESS SCREENING FORM**

We appreciate your cooperation and patience in helping to keep our guests and staff members safe and healthy.

**Have you traveled outside the U.S. in the past 30 days?** YES NO

If yes, where? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Have you traveled to a U.S. City/State with reported cases of COVID-19 in the past 30 days?** YES NO

If yes, where? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Have you been in personal contact with a person infected with COVID-19 or who has traveled to an area with widespread and ongoing transmission of COVID-19 in the past 30 days?** YES NO

**IN THE LAST 48 HOURS:**

**Have you had a fever (99.5°+)?** YES NO

**IN THE LAST 14 DAYS, have you experienced any of the following symptoms:**

* Difficulty breathing/ shortness of breath (not severe)? YES NO
* Coughing? YES NO
* Chills? YES NO
* Repeated shaking and chills? YES NO
* Sore throat? YES NO
* Muscle pain? YES NO
* Headache? YES NO
* Stomach pain? YES NO

Print Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Temperature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Witness: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_