Attestation for COVID-19

Participant name: _____ Date:_____

1. Have you tested positive for COVID-19? Yes ___ No ___

If yes:

Date Symptoms began? _____

Date you were tested? _____

Do you currently have any symptoms associated with COVID-19? Yes___ No___

If yes, what symptoms? _____

2. Do you currently have any of the following that is not explained by another medical condition:

Fever, Cough, shortness of breath or difficulty breathing? Yes___ No___

OR at least 2 of the below symptoms? Yes___ No___

Chills ___ Headache___ Repeated shaking with chills___ Sore throat___

Muscle aches/pain___ New loss of taste or smell___

3. Have you, or anyone in your immediate household, been in close contact with anyone confirmed or presumed positive for COVID-19 in the last 14 days?

Yes___ No___

Close contact is defined as :

Being within approximately 6 feet of a COVID-19 case for a prolonged period of time; close contact can occur while caring for, living with, visiting, or sharing a healthcare waiting room with a COVID-19 case, OR

Having direct contact with infectious secretions of a COVID-19 case (e.g. being coughed on).

4. Have you, or anyone in your immediate household, been asked to quarantine (due to travel, illness, exposure) by state/county mandates/guidance, a health care practitioner, the CDC or DOH in the past 14 days? Yes___ No ___

5. Did you, or anyone in your immediate household, travel internationally or travel on a cruise ship in the past 14 days? Refer to CDC list for all restricted travel locations.

I attest that the information provided is accurate and honest:

Name: _____ Signature:_____ Date:_____