Pearland Archery Club COVID-19 Questionnaire

Participant Last Name: _____ Participant First Name: _____

Participant Last Name: _____ Participant First Name: _____

Participant Last Name: _____ Participant First Name: _____

Answer the questions below for each person entering the building:

Questions	Yes	No
Do you have (or have you had in the past 14 days) a fever of 100.4 or greater?		
Do you have (or have you had in the past 14 days) a cough, shortness of breath or difficulty breathing?		
Do you have (or have you had in the past 14 days) a sore throat, loss of taste or smell?		
Do you have (or have you had in the past 14 days) nausea, diarrhea, vomiting?		
Have you had contact in the past 14 days with someone who has a confirmed diagnosis of COVID-19, someone who is under investigation for COVID-19, or someone who is ill with a respiratory illness?		
Have you or any member of your household had a fever in the past 48 hours?		

I hereby certify that the responses provided above are true and accurate to the best of my knowledge. I understand that falsifying any information on this form could result in the dismissal of participant.

Signature of Participant/Parent/Guardian: _____ Date: _____

Note: The information on this form will be maintained as confidential