

# Health Questionnaire

Name: \_\_\_\_\_

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

Phone: \_\_\_\_\_

Event: Bridal Showcase - Utah St Fairpark

Email: \_\_\_\_\_

Are you experiencing any of the following symptoms:

- Fever (> 100.4 F), Chills or Sweating.
- Shortness of Breath or difficulty Breathing
- Muscle Pain or Aching Throughout Body
- Sudden or New Loss of Taste or Smell
- Vomiting or Diarrhea
- Cough
- Sore Throat

Yes No

Are you taking any medications for these symptoms? Yes No

Is someone you live with experiencing any of these symptoms? Yes No

Is someone you have come into contact with in the last two weeks experiencing any of these symptoms? Yes No

By signing below, I am certifying all information in this form to be accurate to the best of my knowledge:

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

If you are experiencing symptoms related to Covid-19 we ask you to reconsider your attendance to your scheduled event, distance yourself from other attendees and facility employees, seek proper medical attention, and visit our facility again once cleared by a medical provided or are symptom free for 48hrs.

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