CISV Health Questionnaire- COVID-19

In the past 72 hours, have you had any of the following symptoms that are NOT related to any underlying medical condition:

	YES	NO
Fever		
Chills		
Cough		
Shortness of breath or difficulty breathing		
Fatigue (unusual tiredness)		
Headache		
New loss of taste or smell		
Sore throat		
Congestion or runny nose		
Nausea or vomiting		
Diarrhea		
Not feeling well in general		

In the last 72 hours, has anyone in your household tested positive for COVID-19 or had any COVID-19-related symptoms (or any symptoms listed above)? YES_____NO_____

In the last 72 hours, have you been in close contact or around anyone that has tested positive for COVID-19 or has had any COVID-19-related symptoms (or any symptoms listed above)? YES_____NO_____

By completing this questionnaire for my child(ren) and/or myself, I confirm its accuracy.

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Signature of Parent/Guardian/Adult Participant Date

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Name of Parent/Guardian/Adult Participant Name of Minor Participant