



Daily Health Screening Questionnaire
For Program Participants, Patrons, Vendors and Guests
(if under 18 to be completed by parent or guardian)

Dancer's Name (Please Print Clearly): _____

Date: _____

Have you been experiencing any of the following symptoms today or during the past 14 days: fever, shortness of breath, coughing, difficulty breathing, body chills, new loss of taste or smell, headache, muscle pain, sore throat, congestion, nausea or vomiting, and/or diarrhea?

Answer: YES or NO

Have you had close contact with or cared for someone diagnosed with COVID-19 within the last 14 days?

Answer: YES or NO

Have you traveled outside of Illinois in the past 14 days?

Check <https://cookcountypublichealth.org/communicable-diseases/covid-19/covid-19-travel-guidance/> for weekly updates.

Answer: YES or NO

Signature of Person Completing this Form: _____

For internal use:

Access to facility (circle one): Approved Denied

If approved access, name of facility:

Employee name: _____ Employee signature: _____