Cheyenne Civic Center
Health Check Questionnaire

Date:_____/_____/_____ Time:_____

Production: _____

Name _____

Temperature _____*According to the U. S. Centers for Disease Control, in order to attend work, a team member being screened must answer NO to all questions.*

1) Have you experienced the following symptoms in the last 2-14 days? (Y / N)

2) Fever or Chills: (Y / N)

3) Cough: (Y / N)

4) Shortness of breath or difficulty breathing: (Y / N)

5) Fatigue: Y / N

6) Muscle or body aches: (Y / N)

7) Headache: (Y / N)

8) New loss of taste or smell: (Y / N)

9) Sore Throat: Y / N

10) Congestion or runny nose: (Y / N)

11) Nausea or vomiting: (Y / N)

12) Diarrhea: (Y / N)

13) Close contact with an individual displaying any of these symptoms: (Y / N)

14) Close contact with anyone who has tested positive for COVID-19 or is awaiting test results: (Y / N)