HEALTH SCREENING

NAME

EMAIL

PROPERTY ID

DATES OF STAY

NUMBER IN PARTY

NOTES

HAVE YOU OR ANYONE YOU ARE TRAVELING WITH TESTED POSITIVE FOR COVID-19 OR EXPERIENCED ANY OF THE FOLLOWING SYMPTOMS IN THE LAST 14 DAYS ? YES/NO

FEVER	[.]
COUGH	[ ]
SHORTNESS OF BREATH	[ ]
FATIGUE	[ ]
MUSCLE/BODY ACHES	[.]
HEADACHE	[ ]
LOSS OF TASTE/SMELL	[ ]
SORE THROAD	[ ]
CONGESTION	[.]
RUNNY NOSE	[ ]
NAUSEA OR VOMITTING	[ ]
DIARRHEA	[ ]

SIGNED: