COVID-19 Addendum

Name: ______________________ Date: ____________

Have you been tested for COVID-19? ▢ Yes ▢ No

If yes, what type of test did you have? ______________________

When was your test? ______________ What were the results? ______________

Have you been in places with a high infection rate within the last two weeks (e.g., state designated "hotspots")? ▢ Yes ▢ No

Have you had close contact with or cared for someone diagnosed with COVID-19, or someone exhibiting cold or flu like symptoms within the last 14 days? ▢ Yes ▢ No

If yes, please explain. ______________________

Please check if you are experiencing any of the following as a NEW PATTERN since the beginning of the pandemic:

▢ New discomfort with exertion or exercise
▢ Fever
▢ Chills
▢ Cough
▢ Sore throat
▢ Diarrhea, digestive upset
▢ Nasal, sinus congestion
▢ Loss of sense of taste or smell
▢ Fatigue
▢ Shortness of breath
▢ Sudden onset of muscle soreness
▢ Rash or skin lesions (especially on the feet)

I declare that the information provided above is true and accurate to the best of my knowledge.

Print name: ________________________________

Signature: ________________________________