# APPENDIX C

# COVID-19 SCREENING QUESTIONNAIRE FOR FIE EVENT

PARTICIPANT’S NAME: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

DOB: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ MOBILE PHONE:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

EMAIL: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ COUNTRY:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

EVENT: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ VENUE:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

DATE: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Section 1**

|  |  |
| --- | --- |
| Temperature ≥100.1/37.8 |  YES NO - Actual Temperature: |

**Section 2. Do you have any of the following symptoms:**

|  |  |  |
| --- | --- | --- |
| Recent/New Onset Coughing (unrelated to allergy or pulmonary disease) | YES | NO |
| Recent/New Nasal Congestion (unrelated to allergies or sinus infection) | YES | NO |
| Recent/New Onset Sore Throat | YES | NO |
| Recent/New Onset Shortness of breath (unrelated to chronic disease) | YES | NO |
| Recent/New Onset Diarrhea | YES | NO |
| Recent/New Onset Abdominal Pain | YES | NO |
| Recent/New Onset Nausea/Vomiting | YES | NO |
| Recent/New Onset Fatigue/Malaise | YES | NO |
| Recent/New Onset of Loss of Taste/Smell | YES | NO |

**Section 3. Exposure**

|  |  |  |
| --- | --- | --- |
| Are you living with someone who is quarantined? | YES | NO |
| To the best of your knowledge, have you been exposed to or in contact with someone being tested positive for COVID-19 or who has symptoms compatible with COVID-19? | YES | NO |
| For information purpose : If you have previously tested positive for Covid-19 and overcame the infection or if you have been fully vaccinated, please take with you the relevant documentation. |

Participant’s Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_