

SAMPLE - COVID-19 SCREENING

1. Have you experienced any of the following symptoms in the past 48 hours:

- Fever or chills
- Cough
- Shortness of breath or difficulty breathing
- Fatigue
- Muscle or body aches
- Headache
- New loss of taste or smell
- Sore throat
- Congestion or runny nose
- Nausea or vomiting
- Diarrhea

Yes No

2. Within the past 14 days, have you been in close physical contact (6 feet or closer for at least 15 minutes) with a person who is known to have laboratory-confirmed a COVID-19 case or with anyone who has any symptoms consistent with COVID-19?

Yes No

3. Have you been, or are you isolating or quarantining because you may have been exposed to a person with COVID-19 or are worried that you may be sick with COVID-19?

Yes No

4. Are you currently waiting on the results of a COVID-19 test?

Yes No

5. Do you consent to having your temperature checked, wearing PPE, washing your hands and social distancing during the production, including during travel and after hours?

Yes No

6. Do you agree to alert the production company if you test positive for Covid-19 before, during or within 14 days of wrap?

Yes No

Full Legal Name _____

Signature _____ **Date** _____