ATTENDEE HEALTH QUESTIONNAIRE

MOUNTAIN AMERICA EXPOSITION CENTER

Name: _____

Phone #: _____

Email: _____

Date: _____

Event Attending: _____

ARE YOU EXPERIENCING ANY OF THE FOLLOWING SYMPTOMS:

- Fever (>100.4 F), Chills, or Sweating.
- Shortness of Breath or Difficulty Breathing
- Cough
- Vomiting or Diarrhea
- Muscle Pain or Aching Throughout the Body
- Sore Throat
- Sudden or New Loss of Taste or Smell

YES ☐ NO ☐

ARE YOU TAKING ANY MEDICATIONS FOR THESE SYMPTOMS?

YES ☐ NO ☐

IS SOMEONE YOU LIVE WITH EXPERIENCING ANY OF THESE SYMPTOMS?

YES ☐ NO ☐

IS SOMEONE YOU HAVE COME INTO CONTACT WITH IN THE LAST TWO WEEKS EXPERIENCING ANY OF THESE SYMPTOMS?

YES ☐ NO ☐

BY SIGNING BELOW, I AM CERTIFYING ALL INFORMATION ON THIS FORM TO BE ACCURATE TO THE BEST OF MY KNOWLEDGE:

Attendee Signature: _____

If you are experiencing symptoms related to Covid-19 we ask you to; reconsider your attendance to your scheduled event, distance yourself from other attendees and facility employees, seek proper medical attention, and visit our facility again once cleared by a medical provider or you are symptom free for 48hrs.

SALT LAKE COUNTY ASM GLOBAL