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☐

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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** ________________