Giddings YRA Health Self Screening

Please print and have filled out to turn in at entrance to rodeo.

Family's Last Name __________________________________ **Phone #** ________________________________

Family member's first names

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<u>Note: If you refuse to answer the following questions or answer yes to any of the following questions you will be asked to leave.</u>

Please check if you **<u>or</u>** your family have **<u>any</u>** of the following symptoms:

	Cough
	Shortness of breath or difficulty breathing
	Chills
	Repeated shaking with chills
	Muscle pain
	Headache
	Sore Throat
	Loss of taste or smell
	Diarrhea
	Feeling feverish or a measured temperature greater than or equal to 100.00 degrees Fahrenheit
	Known close contact with a person who is lab confirmed to have COVID-19

I confirm all of these answers are correct and agree to follow the rules and guidelines set forth by Lee County and the YRA to ensure a healthy and safe environment.

Signature ____Date _______________