

Health Questionnaire

Theatre Three

[please print]

(date)

(contact phone number)

(contact email)

<i>First name</i>	<i>Last name</i>	<i>Date of birth</i>

(address)

	YES	NO
In the past 48 hours have you experienced any of the following symptoms?		
• Fever of 100.4 degrees Fahrenheit or greater		
• Cough		
• Shortness of breath or difficulty breathing		
• Sore throat		
• New loss of taste or smell		
• Congestion or runny nose not attributed to seasonal allergies		
• Chills; head, body, or muscle aches		
In the past 10 days have you been in close contact* with anyone with the above symptoms or with a confirmed case of COVID-19?		
In the past 10 days have you tested positive for COVID-19 ?		
In the past 10 days have you traveled internationally?		

If you have answered yes to any of these questions, please contact Theatre Three staff

Consent to public gathering risk:

By returning this wellness screening form to Theatre Three staff, I agree that I understand the potential risk of exposure in enjoying this performance. I acknowledge that I will monitor for COVID-19 symptoms for the 14 days following my visit. If I test positive for COVID-19 within 14 days after my visit, I agree to make Theatre Three aware of potential exposure by calling 631-928-9202.

*Close contact is defined as being within six feet of an individual for ten or more minutes within a 24-hour period, starting from two days before their symptoms developed or two days before a positive test (excluding those working in a healthcare setting wearing appropriate PPE)