SYMPTOM QUESTIONNAIRE

Name: ______________________________________ Tour Time/Date: ________________________

Have you experienced any of the following symptoms in the past 24 hours?

	YES	NO
Cough		
Difficulty Breathing		
Vomiting and/or Diarrhea		
Runny Nose		
Sore Throat		
Chills		
Fatigue		
Body Aches		
Fever greater than 100.4		

Have you or any of your household contacts been diagnosed with coronavirus, the flu or had flu-like symptoms within the past 7 days? ◻ YES ◻ NO

Have you or any of your household contacts been exposed to someone with coronavirus, the flu or with flu-like symptoms within the past 7 days? ◻ YES ◻ NO

Have you or any of your household contacts been self-quarantined with coronavirus, the flu or with flu-like symptoms within the past 14 days? ◻ YES ◻ NO

Signature: ____ Date: ________________________

If you have answered YES to any of the above questions, we will be unable to confirm your tour reservation.