

City of Martin FEMA Room / Gateway Center

COVID -19 Questionnaire

Name _____ Date _____

Address _____

Phone Number(s) _____

Have you been exposed to the COVID-19 Virus or been exposed to someone who is actively being evaluated for the COVID-19 Virus? YES _____ NO _____

Have you, or anyone in your household had any of the following symptoms? Y/Yes N/No

- Cough _____
- Runny Nose _____
- Stuffy Nose _____
- Difficulty Breathing _____
- Fever _____
- Chills _____

I attest that all the information submitted above is true to the best of my knowledge.

Signature _____ Date _____