



MEDICAL SCREENING QUESTIONNAIRE

NAME: _____

DATE: _____

TEAM or AFFILIATION: _____

Please complete this form just prior to your arrival at the racing event. This form will be collected at the track Medical Screening Area prior to temperature assessment.

In order to address participant safety and mitigate potential exposure to COVID-19, ROK CUP USA requires screening for COVID-19 symptoms.

1. Have you had **NEW** or worsening cough, sore throat, shortness of breath, nausea, vomiting, diarrhea, muscle aches (not associated with strenuous physical activity) in the past 14 days?
 - a. YES
 - b. NO

2. Have you had a fever of 100° F or higher in the past 72 hours?
 - a. YES
 - b. NO

3. Have you felt feverish or had chills in the past 72 hours?
 - a. YES
 - b. NO

4. Are you experiencing new loss of taste or smell?
 - a. YES
 - b. NO

5. Have you recently been in close contact (less than 6 feet) with anyone experiencing symptoms as mentioned above or who has tested positive for COVID-19?
 - a. YES
 - b. NO

Signature