YRA Health Self Screening

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

Family's Last Name _____ Phone # _____

Address_____

Family members first names

_____

_____

_____

_____

_____

If you refuse to answer the following questions or answer yes to any of the following questions you will be asked to leave.

Please check if you have any 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 sponsoring County and the YRA to ensure a healthy and safe environment.

Signature _____Date _____