

COVID-19 Questionnaire

Family Name: _____ **Date:** _____.____.2021

		Yes	No
1.	Did you travel outside of Germany during the summer break?		
2.	Did you return to Germany more than 2 weeks ago?		
3.	Did you have contact with a person who tested positive for COVID-19?		
4.	Do you have any symptoms? Please check Yes/No for any symptom you are currently exhibiting		
	Fever		
	Fatigue		
	Headache		
	Body Aches		
	Runny Nose		
	Loss of Smell and Taste		
	Sore Throat		
	Persistent cough		
	Shortness of Breath		
	Diarrhea		
5.	Did you take a COVID-19 test already?		
	If so, was it		
	Positive		
	Negative		
	Test Date		

Signature: _____