**­­EXSS Research Participant Wellness Checklist**

|  |  |  |
| --- | --- | --- |
|  | **YES** | **NO** |
| Do you feel like you may have a **temperature greater than 100° F**? (If yes, take temperature). Temperature \_\_\_\_\_\_\_\_\_\_ |  |  |
| Do you have **new muscle aches** not related to another medical condition or activity (e.g. exercise)? |  |  |
| Do you have a **sore throat** not related to another medical condition (e.g. allergies)? |  |  |
| Do you have a **new or worsening cough** that is not related to another medical condition? |  |  |
| Do you have **shortness of breath** that is not related to another medical condition? |  |  |
| Do you have **recent (<5 days) loss of smell or taste**? |  |  |
| Do you have new onset of **vomiting or diarrhea** not related to another medical condition? |  |  |
| Have you had recent close contact with someone who has tested positive for COVID-19? |  |  |
| Have you tested positive for COVID-19? |  |  |
| Have you been quarantined due to COVID-19 symptoms? |  |  |

* If you answered **Yes** to either of the previous two questions:
  + Date of positive COVID-19 test: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
  + Date when asymptomatic: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
  + Have you been cleared by a physician to resume physical activity/exercise? YES \_\_\_\_\_ NO \_\_\_\_\_

**Participant:**

**Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**EXSS Research Personnel:**

**Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**