2020-IMS
MEDICAL SCREENING QUESTIONNAIRE

NAME:_____

DATE:_____

TEAM or AFFILIATION:_____

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

In order to address participant safety and mitigate (as much as possible) potential exposure to COVID-19, INDYCAR requires daily 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 100.4° 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
   c. ☐ I am a healthcare provider- I have been in contact with COVID-19 patients but was wearing appropriate PPE

_____

Signature