TEACHERS as SCHOLARS
A New Vision of Professional Development

TAS COVID-19 Form

Name: _____ Contact Phone: _____

Seminar: _____

1. Are you fully vaccinated? Yes____ No_____
2. Have you tested positive for COVID-19 in the last three weeks? Yes____ No_____
3. Do you have a fever, a dry cough, shortness of breath, or a sudden loss of smell or taste? Yes ____ No _____
4. In the past two weeks, have you spent 10 minutes or more within 6 feet of someone who has tested positive for COVID-19? Yes____ No_____
5. Are you or someone in your household waiting for the results of a COVID-19 test, taken for health reasons (that is, not for travel or other purposes)? Yes____ No_____

Signature: _____

Date: _____