



TEACHERS as SCHOLARS

A New Vision of Professional Development

TAS COVID-19 Form

Name: _____ Contact Phone: _____

Seminar: _____

Day 1 Y or N?	Day 2 Y or N?	
		1. Are you fully vaccinated?
		2. Have you tested positive for COVID-19 in the past 3 weeks?
		3. Do you have a fever, a dry cough, shortness of breath, or a sudden loss of smell or taste?
		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?
		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)?

Signature: _____

Date: _____