COVID-19 Questionnaire

Name: _____________________________  Juror Number: ______

1. Are you 65 years of age or older? □ YES □ NO

2. Do you have any medical conditions that put you at high risk for COVID-19? □ YES □ NO

3. Are you a healthcare worker directly involved with patients who have or are suspected of having COVID-19? □ YES □ NO

4. Are you currently experiencing, any of the following symptoms? □ YES □ NO

Please check the appropriate boxes.
- Chills
- Cough
- Shortness of breath or difficulty breathing
- Fatigue
- Muscle or body aches
- Headache
- New loss of taste or smell
- Sore throat
- Congestion or runny nose
- Conjunctivitis (pink eye)
- Nausea or vomiting
- Diarrhea

5. Do you feel feverish or have a temperature above 100° F? □ YES □ NO

6. In the past 14 days, has anyone in your household tested positive for SARS-CoV-2 or COVID-19? □ YES □ NO

7. In the past 14 days, have you been in close contact with anyone else who has tested positive for COVID-19? □ YES □ NO

8. In the past 14 days, have you tested positive for SARS-CoV2 or COVID-19 or been told by your health care provider that you might have COVID-19? □ YES □ NO

9. In the past 14 days, have you been notified by your public health district that you were or might have been in close contact with someone who tested positive for COVID-19? □ YES □ NO

10. Have you been tested for COVID-19 and are waiting to receive test results? □ YES □ NO

Pursuant to I.C.§ 9-140, I certify or declare under penalty of perjury pursuant to the law of the State of Idaho that the responses are true and correct to the best of my knowledge. I acknowledge that a willful misrepresentation is punishable as a misdemeanor pursuant to I.C. § 2-208(6).

Sign here: _____________________________ Date: ____________