Maple Ski Ridge	Fall Festival Screening Form October 10, 2020				Time Arrived	
Name First Last	**Phone**	**Address**	**In the past 14 days have you had: Fever or chills, cough, trouble breathing, fatigue, muscle aches, Headache, Sore throat, runny nose/congestion, Nausea/vomiting, Diarrhea? Y/N**	**Have you had a Positive COVID test in past 14 days?**	**Exposure to anyone with COVID or suspected COVID in past 14 days?**	**Have you traveled outside of New York State in the past 14 days? If Yes, what state?**