

CASE NAME: _____

JUDGE: _____

ATTORNEYS: _____

BAILIFFS: _____

COURT SECURITY: _____

START TIME: _____

END TIME: _____

ARE YOU EXPERIENCING, OR HAVE YOU EXPERIENCED IN THE LAST TWO WEEKS, ANY OF THE FOLLOWING (Check Mark Indicates No Symptom Reported)														
Name	Juror	Temp.	Exposure to Covid-19	Fever or chills	Cough	Shortness of breath or difficulty breathing	Fatigue	Muscle/body aches	Headache	New loss of taste or smell	Sore throat	Congestion or runny nose	Nausea or vomiting	Diarrhea
1														
2														
3														
4														
5														
6														
7														
8														
9														
10														
11														
12														
13														
14														
15														
16														
17														

Completed By: _____

Signature: _____

Date: _____