1200 Washington Ave, Bay City, Michigan 48708

989-895-4009, PHONE
989-895-4083, FAX
989-895-4049, TDD

James A. Barcia
Bay County Executive

Joel R. Strasz
Public Health Officer

Thomas John Bender, MD, PhD
Medical Director

If you visited the Great American Man Cave in Bay City on 06-23, 06-24, 06-26, or 06-30, then please:

1. Complete this survey and submit it via fax (989-895-4083) or email (covid19@baycounty.net); OR
2. Call the Bay County Health Department (BCHD) (989-895-4009;6).

First Name _____

Last Name _____

Email _____

Primary Phone _____ □ Mobile □ Landline

Please indicate the date(s) when you most recently visited the Great American Man Cave in Bay City.

□ 06-23-2020
□ 06-24-2020
□ 06-26-2020
□ 06-29-2020
□ 06-30-2020

Did you wear a mask during your visit?

□ Yes
□ No

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Are you experiencing any of the following symptoms?

- Please check all new or recent onset symptoms that apply.
- If you are free of any new or recent onset symptoms, then please check the box for “None.”
- You can omit reporting symptoms you attribute to a chronic underlying condition (e.g., cough related to chronic bronchitis) unless your current symptoms represent a departure from your usual norm.

□ None OR

□ Temperature > 100.4°F (38°C)
□ Cough
□ Shortness of breath
□ Sore throat
□ Nausea
□ Vomiting
□ Diarrhea
□ Sweats and/or chills
□ Congestion / runny nose
□ Sudden loss of sense of smell / taste
□ Conjunctivitis (pink eye)
□ Fatigue or weakness
□ Muscle aches
□ Headache

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When did any current or previous symptoms first start?

Start Date ____/____/____

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If you have had symptoms, when did all fever, respiratory symptoms, and gastrointestinal symptoms essentially resolve? If have not had symptoms or your symptoms are on-going and have not resolved, then leave this blank.

- Resolution of fever means without the use of fever-reducing medications (e.g., Tylenol).
- Resolution of respiratory symptoms means substantial improvement in or absence of cough and/or shortness of breath.
- Resolution of gastrointestinal symptoms means substantial improvement in or absence of nausea, vomiting, or diarrhea.

Symptom Resolution Date ____/____/____

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COVID-19 Test Tracking

Have you been tested for COVID-19?

□ Yes
□ No

If you have been tested, please provide these essential details:

Testing Facility Name _____

Phone _____

City _____

State □ MI
□ Other _____

Specimen Collection Date ____/____/____

Specimen Type □ Nasopharyngeal swab □ Nasal swab
□ Oral swab □ Saliva
□ Blood □ Unknown

Test Type □ PCR (looks for viral RNA in secretions)
□ Antibody (looks for antibodies in blood)
□ Antigen (looks for viral proteins in secretions)

Test Result □ Pending
□ Positive
□ Negative
□ Other _____

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