



COLD SORE QUESTIONNAIRE
(To be completed by Artist)



I, (please print name) _____ **DECLARE AND AFFIRM** that the information I am providing below is true and correct (Please PRINT answers):

1. I currently have a cold sore (describe cold sore locations): _____

2. I have had the cold sore since: _____
3. My last cold sore was approximately (date): _____
4. My cold sores usually last (length of time): _____
5. I have had _____ cold sore breakouts over a period of _____ years.
6. My cold sore breakouts are often triggered by (check all that apply):
☐ exposure to sun ☐ cold ☐ stress ☐ other _____
7. To prevent or treat my cold sores, the medication I take is (provide name and dosage): _____

8. I use the above medication under the following circumstances:
☐ before and during filming as a preventative measure
☐ other (describe) _____
9. Name and phone number of prescribing physician: _____
10. My role is: ☐ lead ☐ supporting
11. I am scheduled to be on camera _____ days over a period from _____ to _____

I UNDERSTAND that this COLD SORE QUESTIONNAIRE attaches to and becomes a part of THE FIREMAN'S FUND INSURANCE COMPANY MEDICAL CERTIFICATE & AFFIDAVIT or THE FIREMAN'S FUND INSURANCE COMPANY STATEMENT OF HEALTH & AFFIDAVIT which I have signed, and that all declarations, affirmations, authorizations and recoupment provisions contained therein are for the benefit of Fireman's Fund Insurance Company and its insurance company affiliates (herein after collectively referred to as "Fireman's Fund Insurance Company").

SIGNATURE OF ARTIST _____

Print Artist Name _____ Date _____

GUARDIAN SIGNATURE/RELATIONSHIP _____

Print Name _____ Date _____