COVID-19 HEALTH SCREENING QUESTIONS

Do you have any of these symptoms that are not caused by another condition?

PLEASE ANSWER YES/NO FOR EACH NUMBERED QUESTION.

1. Fever or chills
2. Cough
3. Shortness of breath or difficulty breathing
4. Fatigue
5. Muscle or body aches
6. Headache
7. Recent loss of taste or smell
8. Sore throat
9. Congestion
10. Nausea or vomiting
11. Diarrhea

12. Within the past 14 days, have you had contact with anyone that you know had COVID-19or COVID-like symptoms? Contact is being 6 feet (2 meters) or closer for more than 15minutes with a person, or having direct contact with fluids from a person with COVID-19 (for example, being coughed or sneezed on).

13. Have you had a positive COVID-19 test for active virus in the past 10 days?

14. Within the past 14 days, has a public health or medical professional told you to self-monitor, self-isolate, or self-quarantine because of concerns about COVID-19 infection?