



Screening for COVID-19

1. Do you currently have any symptoms of COVID-19?
 - New cough? Yes | No
 - New shortness of breath or difficulty breathing? Yes | No
 - Fever (100.4°F or higher)? Yes | No
 - New chills? Yes | No
 - New muscle aches? Yes | No
 - New headache? Yes | No
 - New sore throat? Yes | No
 - New loss of taste or smell? Yes | No

2. Have you been in close contact with a someone who tested positive or suspected to be positive for COVID-19? Yes | No

3. Are you currently in isolation or quarantine for COVID-19? Yes | No

4. Have you had a positive test or do you have a pending test for COVID-19? Yes | No