**COVID-19 Self Screening Questionnaire**

* You must answer “NO” to all the questions in this questionnaire in order to enter our location. If you answer “YES” to any of the questions, please **DO NOT** enter the building.

|  |  |  |
| --- | --- | --- |
| * **1) Have you had any of the following symptoms in the last 24 hours? \***
 | **Yes** | **No** |
| Cough |  |  |
| Shortness of breath of difficulty breathing |  |  |
| * **OR at least TWO of the following symptoms in the last 24 hours: \***
 | **Yes** | **No** |
| Fever (usually 100.4 or higher) |  |  |
| Chills |  |  |
| Repeated shaking with chills |  |  |
| Muscle pain |  |  |
| Headache |  |  |
| Sore throat |  |  |
| New loss of taste or smell |  |  |
| * **2) In the last 14 days have you: \***
 | **Yes** | **No** |
| Been in contact with someone who was diagnosed with COVID-19? |  |  |
| Been in close contact with someone who had COVID-19 symptoms? |  |  |
| Traveled to a restricted state, traveled internationally or taken a cruise |  |  |

I certify to the best of my knowledge; this information is accurate.

* Printed Name\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
* Signature \*\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_