Today's Date: _____

Name: _____ Phone: _____

PLEASE READ EACH QUESTION CAREFULLY	PLEASE CIRCLE THE ANSWER THAT APPLIES TO YOU	
Have you experienced any of the following symptoms in the past 48 hours: ● Fever of chills ● Cough ● Shortness of breath or difficulty breathing ● Fatigue ● Muscle or body aches ● Headache ● New loss of taste of smell ● Sore throat ● Congestion or runny nose ● Nausea of vomiting ● Diarrhea	YES	NO
Within the past 14 days, have you been in close physical contact (6 feet or closer for a cumulative total of 15 minutes) with: ● Anyone who is known to have laboratory-confirmed COVID-19? **OR** ● Anyone who has any symptoms consistent with COVID-19?	YES	NO
Are you isolating or quarantining because you may have been exposed to a person with COVID-19 or are worried that you may be sick with COVID-19?	YES	NO
Are you currently waiting on the results of a COVID-19 test?	YES	NO

Signature: _____