**Wellness Form**

1. Do you have a cough?

 Yes No

1. Do you have a fever now or have you in the past 14-21 days?

 Yes No

1. Have you come in contact with any confirmed COVID-19 positive patients in the last 14 days?

 Yes No

1. Are you experiencing shortness of breath or difficulty breathing?

 Yes No

1. Are you experiencing other flu-like symptoms, such as gastrointestinal upset, headache, or fatigue?

 Yes No

1. Have you experienced recent loss of taste or smell?

 Yes No

1. Are you over the age of 60?

 Yes No

1. Do you have heart disease, lung disease, kidney disease, diabetes, or any autoimmune disorders?

Yes No

1. Have you traveled in the past 14 days to any regions affected by COVID-19? (as relevant to your location)

 Yes No

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Print Name

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Signature Date