Name: _____ Date: _____

Have you experienced any of the following symptoms of COVID-19 within the last 48 hours?		
Fever or chills	Yes	No
Cough	Yes	No
Shortness of breath or difficulty breathing	Yes	No
Fatigue	Yes	No
Muscle or body aches	Yes	No
Headache	Yes	No
New loss of taste or smell	Yes	No
Sore throat	Yes	No
Congestion or runny nose	Yes	No
Nausea or vomiting	Yes	No
Diarrhea	Yes	No
Have you tested positive for COVID-19 in the past 10 days?	Yes	No
Are you currently awaiting results from a COVID-19 test?	Yes	No
Have you been diagnosed with COVID-19 by a licensed healthcare provider (for example, a doctor, nurse, pharmacist, or other) in the past 10 days?	Yes	No
Have you been told that you are suspected to have COVID-19 by a licensed healthcare provider in the past 10 days?	Yes	No