



COVID19 Screening Questionnaire

1. Have you experienced any of the following symptoms in the past 48 hours:
 - Fever or chills
 - Cough
 - Shortness of breath or difficulty breathing
 - Fatigue
 - Muscle or body aches
 - Headache
 - New loss of taste or smell
 - Sore throat
 - Congestion or runny nose
 - Nausea or vomiting
 - Diarrhea
2. 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?
 - Anyone who has any symptoms consistent with COVID-19?
3. Are you currently waiting on the results of a COVID-19 test?
4. Within the past 14 days, have you or anyone you have been in close physical contact with traveled within or outside of the United States?