Participant Name:_____

Date:_____

Today or in the past 24 hours, have you or any household members had any of the following symptoms?

- Fever or Chills? YES or NO
- Cough? YES or NO
- Sore Throat? YES or No
- Difficulty breathing YES or NO
- GI symptoms (diarrhea, nausea,vomiting)? YES or NO
- Fatigue YES or NO
- Headache YES or NO
- New loss or taste or smell? YES or NO
- New Muscle aches? YES or NO
- Any signs of illness YES or NO

In the past 14 days, have you had close contact with a person known to be infected with the novel coronavirus (COVID-19)? YES or NO