# METRO SUPPORT SERVICES, INC.
# COVID-19 Symptom Checklist

INDIVIDUAL'S NAME: _____

GUEST NAME: _____

DATE: _____

Have you or anyone in your immediate household had any of the following symptoms in the last 14 days?

❏ Fever
❏ Cough
❏ Shortness of Breath/Trouble Breathing
❏ Chills
❏ Sore Throat
❏ Muscle Pains
❏ New Loss of Taste or Smell
❏ Conjunctivitis/Eye Infection
❏ Nausea
❏ Vomiting
❏ Diarrhea

Comments:
_____
_____
_____

Have you or anyone in your immediate household been in close contact with someone known to have or suspected to have COVID-19 in the last 14 days:

❏ Yes
❏ No

Comments:
_____
_____
_____

Have you or anyone in your immediate household been diagnosed with COVID-19?

❏ Yes If Yes, Date:_____
❏ No