COVID-19 SCREENING QUESTIONNAIRE

1. Have you traveled or had close contact with anyone who has traveled to an area known to be high-risk for COVID-19 in the past 14 days?

   Yes No

2. Have you had any known exposure to a COVID-19 positive person in the last 14 days?

   Yes No

3. Have you been diagnosed with COVID-19 in the past 14 days?

   Yes No

4. Have you been fully vaccinated against COVID-19?

   Yes No

5. In the past 14 days, have you had any of the following symptoms? (circle all that apply)

   Fever (≥100.4°F)

   Cough

   Shortness of breath/ Trouble breathing

   Sore Throat

   Chills

   Muscle aches or rigors

   Headache

   New loss of smell or taste

   Abdominal pain, nausea, vomiting or diarrhea