COVID-19 Screening Questionnaire

The information on this questionnaire will be maintained as confidential.

To ensure the safety of our employees and guests, please complete this screening questionnaire.

1. Have you tested positive for COVID-19? □ No Yes □
2. Are you presumptively positive for COVID-19, based on your health care provider's assessment of your symptoms? □ No Yes □
3. In the past 24 hours, have you experienced any of the following symptoms that you cannot attribute to another health condition:

□ No	Yes □	Cough	Diarrhea	□ No	Yes □
□ No	Yes □	Fatigue	Sore throat	□ No	Yes □
□ No	Yes □	Headache	Nausea or vomiting	□ No	Yes □
□ No	Yes □	Chills	New loss of taste or smell	□ No	Yes □
□ No	Yes □	Muscle or body aches	Congestion or runny nose	□ No	Yes □
□ No	Yes □	Fever of 100.4° F/37.8° C or greater	Shortness of breath or difficulty breathing	□ No	Yes □

4. In the past 14 days, have you been in close contact with anyone exhibiting any symptoms listed in Question 3 above that you cannot attribute to another health condition? *Close contact is defined as someone who has spent 15 or more minutes within 6 feet of a person who exhibits COVID-19 symptoms (such as those listed in question 3).* □ No Yes □
5. In the past 14 days, have you been in close contact with anyone who tested positive for COVID-19? *Close contact is defined as someone who has spent 15 or more minutes within 6 feet of a person who exhibits COVID-19 symptoms (such as those listed in question 3).* □ No Yes □
6. In the past 14 days, have you been in close contact with anyone who has self-quarantined? *Close contact is defined as someone who has spent 15 or more minutes within 6 feet of a person who exhibits COVID-19 symptoms (such as those listed in question 3).* □ No Yes □

Certification

My signature acknowledges that all the information provided is accurate and true to the best of my knowledge.

_____/_____ _____

Printed Name & Signature Date