COVID-19 Daily Pre-screening Questions

1. Do you have any of these symptoms that are not caused by another condition?

- Fever or chills
- Cough
- Shortness of breath or difficulty breathing
- Fatigue
- Muscle or body aches
- Headache
- Recent loss of taste or smell
- Sore throat
- Congestion
- Nausea or vomiting
- Diarrhea

2. Within the past 14 days, have you had contact with anyone that you know had COVID-19 or COVID-like symptoms? Contact is being 6 feet (2 meters) or closer for more than 15 minutes with a person, or having direct contact with fluids from a person with COVID-19 (for example, being coughed or sneezed on).

3. Have you had a positive COVID-19 test for active virus in the past 10 days?

4. Within the past 14 days, has a public health or medical professional told you to self-monitor, self-isolate, or self-quarantine because of concerns about COVID-19 infection?

Initial HERE to confirm a NO answer to ALL above questions: _____

5. Temp Check (>100.4 F) _____

Name: _____

Signature / Date: _____

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