COVID-19 SELF SCREENING

1. Have you had a fever in the last 5 days?
(Fever is defined as: above 99.4* on forehead with a non-contact infrared thermometer)

2. Have you had a cough in the last 5 days?

3. Have you had a sore throat in the last 5 days?

4. Do you feel any tightness or heaviness in your chest?

5. Has someone in your home been diagnosed with COVID-19?

6. Have you been around anyone who has been sick?

7. Have you been around anyone who has been diagnosed with COVID-19?

8. Have you traveled out of the US in the last 2 weeks?

9. Have you had any of these symptoms in the last 2 weeks?
- Shortness of breath or difficulty breathing
- Chills
- Repeated shaking with chills
- Muscle pain
- Headache
- New loss of taste or smell

IF YOU HAVE ANSWERED YES TO ANY OF THE ABOVE,
Please do not enter the building until you speak with Rachel or Kristin.
Please call the office at 360-659-7777 to discuss if you can enter the building.