**Name:**

**Date:**

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 or closer for more than 15 minutes with a person, or having direct contact with fluid from a person with COVID-19 (such as being coughed or sneezed on).

**YES NO**

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

**YES NO**

1. 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?

**YES NO**