COVID-19 Screening Questionnaire

Have you

		Yes	No
1.	Knowingly been in close or proximate contact in the past 14 days with anyone who has tested positive for COVID-19 or who has or had symptoms of COVID-19?		
2.	Tested positive for COVID-19?		
3.	Experienced any symptoms of COVID-19, including cough, fever, chills, muscle pain, shortness of breath or difficulty breathing, sore throat or new loss of taste or smell in the past 14 days?		

Print Name

Signature