HEALTH SCREENING

PLEASE ANSWER YES OR NO TO THE FOLLOWING QUESTIONS:

1. **HAVE YOU BEEN DIAGNOSED WITH COVID 19 IN THE LAST 21 DAYS? YES_____ NO_____**
2. **HAVE YOU BEEN IN CLOSE CONTACT WITH ANYONE WHO HAS TESTED POSITIVE FOR COVID 19 IN THE LAST 14 DAYS? YES_____ NO_____**
3. **HAVE YOU EXPERIENCED HAVE ANY OF THE FOLLOWING SYMPTOMS IN THE LAST 14 DAYS:**
   - **FEVER OF OVER 99.9**
   - **CONGESTION OR RUNNY NOSE**
   - **COUGH**
   - **FATIGUE**
   - **SHORTNESS OF BREATH OR DIFFICULTY BREATHING**
   - **CHILLS**
   - **MUSCLE PAIN**
   - **SORE THROAT**
   - **RECENT LOSS OF TASTE OR SMELL YES_____ NO_____**

I CONFIRM THAT ALL OF THE ABOVE ANSWERS ARE TRUE.

NAME_____SIGNATURE_____

DATE_____TELEPHONE#_____