Name ___________________________________ Temp ________ Date _____________

Within The Last 14 Days Have You Experienced Any Of The Following Symptoms:

	Yes	No
Fever	☐	☐
Cough	☐	☐
Shortness of Breath OR Difficulty Breathing	☐	☐
Chills	☐	☐
New Loss of Taste OR Smell	☐	☐
Muscle Pain	☐	☐
Sore Throat	☐	☐
Extreme Fatigue	☐	☐
Have You traveled internationally, to any areas where COVID is widespread or been on a cruise ship in the last 14 days?	☐	☐
Have You OR A Member of Your Household had close contact with Or cared for Someone Diagnosed With COVID-19 in the last 14 days?	☐	☐
Have You OR A Member of Your Household had close contact with OR cared For Someone With A Presumptive Positive Case Of COVID-19 in the last 14 days?	☐	☐
Have You or A Member of Your Household been asked OR Required to Quarantine based on contact with a person who has a Confirmed OR Presumptive Positive COVID-19 Test Result?	☐	☐