



Health Screening Questionnaire

Print Name: _____

Date: _____

1. The following symptoms may appear 2 to 14 days after exposure to COVID-19:
 - Fever or chills
 - Cough
 - Shortness of breath or difficulty breathing
 - Fatigue
 - Muscle or body aches
 - Headache
 - New loss of taste or smell
 - Sore throat
 - Congestion or runny nose
 - Nausea or vomiting
 - Diarrhea

Have you had any of these symptoms in the past 14 days?

YES

NO

2. **Have you tested positive for a COVID-19 test in the last 14 days?**

YES

NO

3. **Have you had close contact with a confirmed or suspected COVID-19 case in past 14 days?**

YES

NO

To the best of my knowledge, I certify the above is true and correct.

Signature

Print Name

Date

Reviewed by:

Signature

Print Name

Date