Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

1. Have you been in close contact with anyone who has been clinically diagnosed with Covid-19 in the last 14 days?   Y  / N
2. Have you within the past 3 days had a fever of 100.0F or more?     Y  / N
3. Have you within the past 14 days experienced any respiratory problems (trouble breathing, persistent cough, shortness of breath, chest congestion?   Y / N
4. Have you within the past 14 days experienced:  chills, body aches, nausea, diarrhea, vomiting, loss of smell, taste, or appetite, eye infections, fatigue, dizziness?  Y/ N
5. Have you recently visited a Hospital or Emergency Room?           Y / N
6. Have you been in close contact with anyone who has traveled outside of the United States in the last 14 days?  Y/N