COVID-19 SELF- SCREENING ASSESSMENT

do not enter

Please respond to each of the following questions, truthfully, commonsensically and to the best of your ability.

1	Are you currently experiencing, or have you experienced in the past 14 days, any of the following symptoms? (***Please take your temperature before you answer this question.)***		
	Yes	No	Fever (100.4° F/37.8° C measured by a thermometer)
	Yes	No	Cough
	Yes	No	Shortness of breath or difficulty breathing
	Yes	No	Sore throat
	Yes	No	New loss of taste or smell
	Yes	No	Chills
	Yes	No	Head or muscle aches
	Yes	No	Nausea, diarrhea, vomiting, new GI symptoms
	Yes	No	Runny nose, or new sinus congestion
2			