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| **Check YES or NO for each question. Since your last day of entrance into the facility have you had any of the following symptoms?** | **Yes** | **No** |
| Feeling feverish and/or having chills –documented temperature of 100.4°F orhigher? | ☐ | ☐ |
| Has there been any use of fever reducing medication within the last three days? | ☐ | ☐ |
| A new cough that is not due to another health condition? | ☐ | ☐ |
| New shortness of breath or difficulty breathing that is not due to another health condition? | ☐ | ☐ |
| New chills that are not due to another health condition? | ☐ | ☐ |
| A new sore throat that is not due to another health condition? | ☐ | ☐ |
| New muscle aches that are not due to another health condition, or that may havebeen caused by a specific activity (such as physical exercise)? | ☐ | ☐ |
| A new loss of taste or smell? | ☐ | ☐ |
| Have you had a positive test for the virus that causes COVID-19 disease within the past 10 days? | ☐ | ☐ |
| In the past 14 days, have you had close contact (within about 6 feet for 15 minutes or more) with someone with suspected or confirmed COVID-19? | ☐ | ☐ |
| In the past 14 days, have you or had close contact (within about 6 feet for 15 minutes or more) with someone who has traveled to a known COVID-19 hotspot. |  ☐ |  ☐ |
| In the past 14 days, have you or had close contact (within about 6 feet for 15 minutes or more) with someone who has been on a commercial flight or traveled outside of the United States? |  ☐ |  ☐ |