COVID-19 HEALTH SCREENING

<table>
<tr><th>PLEASE READ EACH
QUESTION CAREFULLY</th><th colspan="2">Please circle the answer that applies to you.</th></tr>
<tr><td>Have you experienced any of the following symptoms in the past 48 hours:
● 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</td><td>YES</td><td>NO</td></tr>
<tr><td>Within the past 14 days, have you been in close physical contact (6 feet or closer for a cumulative total of 15 minutes) with:

● Anyone who is known to have laboratory-confirmed COVID-19?
OR
● Anyone who has any symptoms consistent with COVID-19?</td><td>YES</td><td>NO</td></tr>
<tr><td>Are you isolating or quarantining because you may have been exposed to a person with COVID-19 or are worried that you may be sick with COVID-19?</td><td>YES</td><td>NO</td></tr>
<tr><td>Are you currently waiting on the results of a COVID-19 test?</td><td>YES</td><td>NO</td></tr>
</table>

Did you answer **NO** to **ALL QUESTIONS**?	You are approved for entry to our facilities.
Did you answer **YES** to ***ANY* QUESTION**?	**Access to facilities are NOT approved.**