Covid-19 Questionnaire

1) Do you have any of the following symptoms or have you experienced any of these symptoms in the last 14 days?

Check all that apply.

Fever of 100.4 F (38 C) or above, or possible fever symptoms like alternating chills and sweating

Cough

Trouble breathing, shortness of breath or severe wheezing

Chills or repeated shaking with chills

Muscle aches

Sore throat

Diarrhea

Loss of smell or taste, or a change in taste

Headache

None of the above

2) Have you been within 6 feet of a person with a lab-confirmed case of COVID-19 for at least 5 minutes, or had direct contact with their mucus or saliva, in the past 14 days?

Yes No

3) I attest that this is an accurate representation of my symptoms and contact information

Signature ______________________________ Date ______________________