COVID-19 Screening Questions

1. Do you have **ANY of the following symptoms** (not caused by a chronic condition)?

   Cough
   Fever (above 100.4°F) or Chills
   Shortness of Breath or Difficulty Breathing
   Fatigue
   Muscle or Body Aches
   Headache
   Recent Loss of Taste or Smell
   Sore Throat
   Congestion
   Nausea or Vomiting
   Diarrhea

2. **COVID-19 Testing (PCR or Antigen)**: Are you awaiting results or have you tested positive in the past 10 days?

3. **Close Contact:** In the past 5 days, have you been in close contact with a confirmed COVID-19 positive individual?

4. **Quarantine/Isolate:** Has any medical/public health official/school official asked you to quarantine/isolate in the past 10 days?

5. **Household Member:** Does anyone in your household have COVID-19 symptoms, or have they tested positive for COVID-19, or have they been told to quarantine/isolate, in the past 10 days?