DATE:_____

1. Have you had any COVID-19 symptoms in past 14 days such as but not limited to,

   Cough
   Shortness of breath or difficulty breathing
   Fever
   Chills
   Muscle pain
   Sore throat
   New loss of taste or smell,
   (less common) gastrointestinal symptoms like nausea, vomiting or diarrhea,

   or have you tested positive for COVID-19 in the past 14 days,

   or have you been in close contact with a confirmed or suspected COVID-19 case in the past 14 days?

Name	Phone	GO	No

**** Note, if your answer is GO, please leave immediately. Thank you! Also, the phone number will be used in contacting if it becomes necessary. **Pg. 22 (10/08/2020)**