COVID-19 Screening Questionnaire:

Have you had a fever in the last 24 hours of 100°F or above?
Yes □ No □

Do you now, or have you recently had, any respiratory or flu symptoms?
(including fever, chills, sore throat, cough, muscle aches, or shortness of breath)
Yes □ No □

Have you been in contact with anyone in the last 14 days who has been diagnosed with COVID-19 or has coronavirus-type symptoms?
Yes □ No □

Have you traveled anywhere outside of the state in the last two weeks?
Yes □ No □

Have you had a new loss of sense of taste or smell?
Yes □ No □

Can you exercise to get your heart rate and respiratory rate up without any problem?
Yes □ No □

Have you had a new onset of muscle aches and pain since the emergence of the virus?
Yes □ No □

Have you seen any new marks, rashes, spots, bumps, or other lesions on your skin?
Yes □ No □