Health Questionnaire

1. Have you traveled outside of the country in the last 14 days?

NO ◯ YES ◯

2. Have you traveled outside of the state in the last 14 days?

NO ◯ YES ◯

3.Have you had contact with anyone with confirmed COVID-19 in the last 14 days?

NO ◯ YES ◯

4. Have you had any of these symptoms in the last 14 days

-Fever greater than 100 NO ◯ YES ◯

-Difficulty breathing NO ◯ YES ◯

-Cough NO ◯ YES ◯

-Sore Throat NO ◯ YES ◯

Date: _____

Printed Name: _____

Signature:_____