APPENDIX A

COVID-19 HEALTH SCREENING QUESTIONNAIRE

Do you, or anyone you are living with, have any of these symptoms: fever (100.4 or higher), cough, shortness of breath or difficulty breathing, diarrhea, chills, headache, severe sore throat, muscle aches, new loss of taste or smell?

☐ Yes ☐ No

Have you or anyone you are living with, been diagnosed by a positive test and/or a health care practitioner for COVID-19 in the past month?

☐ Yes ☐ No

Have you, or anyone you are living with, been in *close contact* (e.g., withing 6 feet for more than a few minutes) with a person with confirmed COVID-19 infection in the past month?

☐ Yes ☐ No

If you have answered yes, please do not enter the building.

Name ____________________________ Date ______________