Health Questionnaire

Name:_________________________

1) Have you or someone that lives in your household had any travel within the past 14 days?

2) Have you had any signs or symptoms of a respiratory infection, such as a fever, cough, shortness of breath, sore throat, chills, repeated shaking with chills, muscle pain or loss of taste?

3) In the last 14 days have you had contact with someone with a confirmed diagnosis of COVID-19, or who is under assessment for COVID19, or has been ill with respiratory illness?

4) Do you consider yourself as being in the high-risk category for COVID-19 as defined by the CDC? High Risk - Older adult or someone with a serious chronic medical condition, or anyone with a chronic disease such as heart disease, diabetes, lung disease, immune-compromised disease, liver disease, chronic kidney disease, are receiving treatments that may compromise one's immune system?

5) Is your temperature 100.4 F or above?

Signature____