Appendix A: Health Screening Questionnaire

COVID-19 HEALTH QUESTIONNAIRE

DATE: _____

NAME: _____

QUESTIONS:

1) **Have you experienced symptoms of COVID-19 such as fever (temperature of 100°F or above) or chills, muscle or body aches, cough, shortness of breath or difficulty breathing, fatigue, headache, sore throat, nasal congestion or runny nose, nausea or vomiting, diarrhea, or new loss of taste and/or smell in the past 10 days?**

   Please answer "yes" only if you are experiencing a new onset of symptoms OR you are experiencing a change in symptoms from your baseline if you have a known pre-existing medical condition (e.g. asthma, allergies).

☐ No ☐ Yes

2) **Is your temperature 100 degrees Fahrenheit or greater today?**

☐ No ☐ Yes

3) **Have you tested positive for COVID-19 in the past 10 days?**

☐ No ☐ Yes

4) **Have you had contact with anyone confirmed or suspected of having COVID-19 in the past 10 days?**

☐ No ☐ Yes

If you checked YES to any of the above questions, please STOP and notify administration immediately

SIGNATURE: _____

8/19/2021