COVID-19 SCREENING QUESTIONNAIRE

1. To the best of your knowledge have you had direct contact with someone that has tested positive for, or who is suspected of having COVID-19 in the past 14 days? **YES / NO**
2. Do you feel feverish or have a temperature over 100.0 degrees? **YES / NO**
3. Do you have a new (last 72 hours) persistent cough or difficulty breathing? **YES / NO**
4. Have you been told to quarantine by the public health department? **YES / NO**
5. Have you travelled outside of the state within the past 14 days? **YES / NO**
   If yes, WHERE:_____

*****If you answered "Yes" to any of the questions above, you and your group will not be allowed to enter the building.*****

TO THE BEST OF MY KNOWLEDGE MY ANSWERS ARE TRUE.

_____

PRINT NAME & SIGNATURE

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