CLEAN, SAFE & READY

BECAUSE YOU'RE OUR PRIORITY

SYMPTOM SCREENING QUESTIONS

	QUESTION	YES	NO
1	Have you had any signs or symptoms of a fever in the past 24 hours, such as: chills, sweats, felt "feverish" or had a temperature that is elevated for you/100.4°F or greater?	☐	☐
2	Have you had any of the following COVID-19 symptoms?		
	Cough	☐	☐
	Shortness of Breath or Chest Tightness	☐	☐
	Sore Throat	☐	☐
	Nasal Congestion/Runny Nose	☐	☐
	Myalgia (body aches)	☐	☐
	Loss of Taste and/or Smell	☐	☐
	Diarrhea	☐	☐
	Nausea	☐	☐
	Vomiting	☐	☐
	Headache	☐	☐
3	Do you live with someone who has tested positive for or has symptoms of COVID-19?	☐	☐
4	Have you been closer than 6 feet for more than 15 minutes to someone who has tested positive for or has symptoms of COVID-19?	☐	☐

WE ARE HERE FOR OUR COMMUNITY.
WE ARE HERE FOR YOU.