

## **Have you had any of the following symptoms within the past 24 hours?**

1. Temperature of 100.4 degrees Fahrenheit or higher when taken by mouth?
2. Sore Throat?
3. New, uncontrolled cough that causes difficulty breathing?
4. Diarrhea, vomiting or abdominal pain?
5. New onset of severe headache, especially with a fever?
6. Loss of taste and/or smell?

## **Have / Are You or anyone in your immediate family:**

1. Tested positive for COVID-19 during the last 14 days?
2. Waiting for a COVID-19 test result?
3. Been exposed to anyone who has tested positive for COVID-19 within the past 14 days?

