Full Name: _____ Date: _____

1. Do you have any of the following:
    a. Fever or chills
    b. Cough
    c. Shortness of breath or difficulty breathing
    d. Fatigue
    e. Muscle or body aches
    f. Headache
    g. New loss of taste or smell
    h. Sore throat
    i. Congestion or runny nose
    j. Nausea or vomiting
    k. Diarrhea

    ☐ Yes ☐ No

2. Are you ill, caring for someone who is ill, or had contact with someone who has symptoms of COVID-19 as listed in question 2?

    ☐ Yes ☐ No

3. In the last two weeks did you have contact with someone diagnosed with COVID-19 or has symptoms of COVID-19?

    ☐ Yes ☐ No

4. I am self-certifying that I am feeling well and have not had contact with anyone COVID-19 positive or anyone who has symptoms of COVID-19

    ☐ Yes ☐ No

If you answered "No" to each question, you are approved to enter the facility. If you feel ill at any time while visiting this facility, please inform staff and return to your home.