COVID-19 QUESTIONAIRE:

Question		
Have you or anyone in your household had any of the following symptoms in the last 21 days: sore throat, cough, chills, body aches for unknown reasons, shortness of breath for unknown reasons, loss of smell, loss of taste, fever at or greater than 100 degrees Fahrenheit?	**YES**	**NO**
Have you or anyone in your household cared for an individual who is in quarantine or is a presumptive positive or has tested positive for COVID-19 in the past 14 days?	**YES**	**NO**
Do you or anyone in your household work with positive COVID-19 patients?	**YES**	**NO**
Have you or anyone in your household, visited or received treatment in a hospital, nursing home, long-term care, or other health care facility in past 30 days?	**YES**	**NO**
IF you circled yes to any of the previous questions, have you been tested for COVID-19 in the past 14 days? **IF YES, have you received the results yet? _______________** **Result: __________________**	**YES**	**NO**
Have you received the COVID-19 vaccine?	**YES**	**NO**

Please sign and date to confirm all information provided above is correct:

Signature: **Date:**