COVID-19 SCREENING QUESTIONS

- Have you had any symptoms of: Y/N
    - Sore throat
    - Vomiting
    - New or worsening cough
    - Diarrhea
    - A loss of smell or taste
    - Fever/High temperature
    - Difficulty breathing
    - NO SYMPTOMS PRESENT
- Have you ever tested positive for Covid in the last 14 days? Y/N
- Have you been around anyone that has tested positive for COVID in the last 2 weeks? Y/N
- Have you travelled out of state in the last 14 days? Y/N?
  *If Yes please quarantine for 2 weeks