COVID SELF ASSESSMENT QUESTIONNAIRE

1.Have you had a fever in the last 24 hours (greater or equal to 100.1)?

- Yes
- No

2.Have you had in the last 72 hours any of the symptoms associated with COVID 19?

- Yes
- No

3.Have you been in close contact with someone who was diagnosed with COVID 19 and still has symptoms?

- Yes
- No

4.Have you experienced any of the following symptoms in the last 48-hours:

- Fever or chills
- Cough
- Shortness of breath or difficulty breathing
- Fatigue
- Muscle or body aches
- Headache
- New loss of taste or smell
- Sore throat
- Congestion or runny nose
- Nausea or vomiting
- diarrhea

- Yes
- No