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COVID-19 Screening Questions

1. Have you have any of the following?

[ ] Fever

[ ] Cough

[ ] Chills

[ ] Repeated shaking with chills

[ ] Muscle pain

[ ] Headache

[ ] Sore throat

[ ] New loss of tase or smell

2. Are you ill, or caring for someone who is ill?

In the two weeks before you felt sick, did you:

[ ] Have contact with someone diagnosed with COVID-19?

[ ] Live in or visit a place where COVID-19 is spreading?