|  |  |
| --- | --- |
| **1. Are you currently feeling sick with any of the following Symptoms: Fever, cough (not due to allergies), chills, sore throat, shortness of breath, loss of smell or taste, muscle aches, headache\*** | Yes No  NO: proceed to question 3. YES: See below \*\* |
| **Have you been tested for the virus that causes COVID-19 with a positive or pending result in the last 14 days?\*** | Yes No  NO: Proceed to question 4. YES: see \*\* below |
| **In the past 14 days, have you had close contact (within 6ft for 15 minutes or more) with someone suspect or confirmed with COVID-19?\*** | Yes No  NO: Proceed to question 5. YES: See \*\* below |
| **Are you arriving/returning from out of the local area in the last 14 days?\*** | Yes No |