COVID-19 SCREENING QUESTIONAIRE

PLEASE READ EACH QUESTION CAREFULLY

PLEASE ANSWER THE QUESTIONS THAT APPLY TO YOU

ADDRESS:

	YES	NO
1. Do you have any of these symptoms that are not caused by another condition?		
• Fever or chills	☐	☐
• Cough	☐	☐
• Shortness of breath or difficulty breathing	☐	☐
• Fatigue	☐	☐
• Muscle or body aches	☐	☐
• Headache	☐	☐
• Recent loss of taste or smell	☐	☐
• Sore throat	☐	☐
• Congestion or runny nose	☐	☐
• Nausea or vomiting	☐	☐
• Diarrhea	☐	☐

	YES	NO
2. Within the past 14 days, have you been in close physical contact with anyone that you know had COVID-19 or COVID-19 like symptoms? Close physical contact is being 6 feet (2 meters) or closer for more than 15 minutes, with a person or having direct contact with fluids from a person with COVID-19? (for example, being coughed or sneezed on)	☐	☐

	YES	NO
3. Have you tested positive for active COVID-19 virus in the past 10 days or are you currently awaiting the results of a COVID-19 test?	☐	☐

	YES	NO
4. Within the past 14 days, have you been directed by a public health or medical professional to self-monitor, self-isolate, or self-quarantine because of concerns about COVID-19 infection?	☐	☐

	YES	NO
Within the past 14 days, have you traveled internationally, or to any state or U.S. jurisdiction on the list of "impacted states" under New Jersey's COVID-19 travel advisory?	☐	☐

SIGNATURE **DATE**

PRINT NAME