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| **Location:** | **Date:** |
| **Name****Y/N for each question** | *Do you have any of these symptoms that are not caused by another condition?*• Fever or chills• Cough• Shortness of breath or difficultybreathing• Fatigue• Muscle or body aches• Headache• Recent loss of taste or smell• Sore throat• Congestion• Nausea or vomiting• Diarrhea | *If you are* ***not*** *fully vaccinated, have you been in close contact with anyone with COVID19 in the past 14 days? Close contact is being within 6 feet for 15 minutes or more over a 24-hour period with a person; or having direct contact with fluids from a person with COVID-19 with or without wearing a mask (i.e., being coughed or sneezed on).* | *Have you had a positive COVID-19 test for active virus in the past 10 days, or are you awaiting results of a COVID-19 test?* | *Within the past 14 days, has a public health or medical professional told you to self-monitor, self-isolate, or self-quarantine because of concerns about COVID-19 infection?* | *Temp check?* |
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