In the past 24 hours, have you experienced?	In the past 24 hours, have you experienced?
Fever: ☐ Yes ☐ No	Fever: ☐ Yes ☐ No
Fatigue: ☐ Yes ☐ No	Fatigue: ☐ Yes ☐ No
Cough: ☐ Yes ☐ No	Cough: ☐ Yes ☐ No
Sneezing: ☐ Yes ☐ No	Sneezing: ☐ Yes ☐ No
Aches and Pains: ☐ Yes ☐ No	Aches and Pains: ☐ Yes ☐ No
Runny or Stuffy Nose: ☐ Yes ☐ No	Runny or Stuffy Nose: ☐ Yes ☐ No
Sore throat: ☐ Yes ☐ No	Sore throat: ☐ Yes ☐ No
Diarrhea: ☐ Yes ☐ No	Diarrhea: ☐ Yes ☐ No
Headaches: ☐ Yes ☐ No	Headaches: ☐ Yes ☐ No
Shortness of breath: ☐ Yes ☐ No	Shortness of breath: ☐ Yes ☐ No
Have you recently been in close contact with anyone who has	Have you recently been in close contact with anyone who has
exhibited any symptoms?	exhibited any symptoms?
☐ Yes ☐ No	☐ Yes ☐ No
Have you recently been in contact with anyone who has tested	Have you recently been in contact with anyone who has tested
positive for COVID-19?	positive for COVID-19?
☐ Yes ☐ No	☐ Yes ☐ No