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