



## COVID-19 SCREENING QUESTIONS

I) Has an individual in your household experienced any of the following symptoms of COVID-19 in the past 48-hours?

- FEVER OR CHILLS
- COUGH
- SHORTNESS OF BREATH OR DIFFICULTY BREATHING
- FATIGUE
- MUSCLE OR BODY ACHES
- HEADACHE
- NEW LOSS OF TASTE OR SMELL
- SORE THROAT
- CONGESTION OR RUNNY NOSE
- NAUSEA OR VOMITING
- DIARRHEA

II) Have you/has your child been in close physical contact with a person who is known to have a **confirmed case** of COVID-19?

III) Have you/has your child been in close physical contact with anyone who has any **known symptoms** consistent with COVID-19?

IV) Is an individual within your household currently quarantined because of possible exposure to a person with COVID-19 **or** because they are worried they may be sick with COVID-19?

V) Is anyone in your household currently awaiting the results of a COVID-19 test?

*Close physical contact = within 6 feet or closer for a minimum of 15 minutes*